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A CLINICAL LECTURE.

PERITYPHLITIS.

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DELIVERED AT THE HOSPITAL OF THE UNIVERSITY OF PENNSYLVANIA.

[Reported for THE BULLETIN by WM. H. MORRISON, M.D.]

GENTLEMEN: The lad whom I bring before you to-day has been in the hospital some little time. I shall in the first place briefly give you the history. He is 19 years of age, and was admitted to the hospital, June 19th, three and a half months ago. His family history appears to be good. He, himself, had measles when a child, but was always well until three years ago when he had an acute, painful affection of the bowels which he thinks resembles the attacks which he has recently had. Since that time he has been constipated and has been obliged to use purgatives. The present trouble began on the first of June, with a spell of diarrhœa lasting for a couple of weeks. When he came to the hospital, the bowels were quiet and remained so until an enema was administered, when he discharged hard, scybalous masses, covered with mucus. He had a little fever, with a temperature of 101° and a pulse of 80. He complained of some pain when pressure was made over the right iliac fossa, and in this region a sense of resistance was found on palpation. The abdominal walls were tightly stretched, and there was a little distension of the belly. He complained from time to time of slight colicky pains. He was at once put to bed and

given a diet consisting largely of milk. He soon improved and the diet was made more liberal. At the close of June he had an attack of pain in the right side and this was followed by a little diarrhœa, which soon subsided, and was followed by constipation. At this time there was an increased induration in the right iliac fossa, and with the finger in the rectum this induration on the right side could be felt. The discharges from the bowel contained mucus but no blood. He again improved under treatment, the stools became more natural, and he was allowed to move about a little. July 27th, he had another attack of pain and he was put to bed. There was a return of the feeling of induration and of tenderness on pressure. This mass persisted, and although it was blistered, it did not disappear so rapidly as on former occasions. The bowels continued constipated and enemas were required. The evacuations obtained consisted of hard matter coated with mucus. Through the month of August he continued pretty well, but on the 29th of August he had another spell of pain and the mass in the right side increased in size, was hard, gurgled when pressed upon, and was tender to the touch. He was again confined to bed, his condition improved, the fever disappeared, the mass subsided, and he was allowed to take more food. Since September 1st (four weeks) he has had from time to time a little increase of pain but no distinct attack.

As you will have noted, he has since coming under observation presented a series of attacks, all of which were of the same character. There has been a little fever with diarrhœa, the stools containing mucus; following this there has been constipation, with increased pain, hardening,

and swelling, in the right iliac fossa. These symptoms have then subsided and the patient improved in every respect, and then from some cause there has been a relapse. Three years ago he had a spell which he thinks was of the same character, and in all probability it was. This is then a case of inflammation in the right iliac region.

There are certain conditions affecting this region which are met with so frequently that it is desirable that we should have a most intimate acquaintance with them. In the first place, we have typhlitis, or inflammation of the walls of the cæcum; in the second place we have perityphlitis or inflammation of the cellular tissue surrounding the cæcum. These two conditions are very constantly associated with each other.

The attack may be one of pure typhlitis, the wall of the bowel alone being affected. This may be a simple inflammation, or there may be ulceration which may go on to perforation. More frequently, however, with the inflammation of the wall of the bowel there is inflammation of the cellular tissue around the bowel, so that the typhlitis is associated with perityphlitis. Again perityphlitis may be the first affection and the inflammation may chiefly affect the cellular tissue between the bowel and the iliac fossa. The condition may remain one of perityphlitis and may go on to produce swelling and exudation which may soften with the production of an abscess, and the wall of the cæcum may sympathize very little in the process. As a rule, however, the cæcum becomes involved in the inflammation.

The inflammation is attended with swelling from congestion, and from effusion, and from thickening of the tissues. This swelling manifests itself as a fulness in the right iliac fossa. The extent of this fulness varies, in some cases it is slight, while in others it may form a considerable mass extending several inches inward toward the median line of the abdomen. In most cases part of this fulness is due to impaction of feces in the cæcum. When the coats of the bowel are inflamed and irritated, its propulsive power is for the time lost, and the fecal matter which enters the cæcum is not forced onward, and as a result impaction occurs. In these cases the fulness will be dull on percussion. In other cases the fulness is dependent more upon thickening of the pericæcal tissue, and although there may be con-

siderable resistance on pressure, yet percussion gives resonance. As I have already said, the inflammation may begin inside and extend through the coat of the bowel irritating the pericæcal tissue, and may even cause perforation of the cæcum. When it perforates the bowel it causes a pericæcal abscess. The inflammation may begin in the pericæcal tissue, and the exudation following may run on to suppuration and we again have a pericæcal abscess. Cases of typhlitis and perityphlitis may terminate either in resolution with removal of the effusion, or in abscess coming from perforation or from the violence of the inflammation. This is a possible result which is always to be borne in mind. In addition to the pain, fulness, and hardness in the iliac fossa, it will often be found that the mucous membrane of the bowel shows evidences of irritation. Not rarely there is for a day or two diarrhoea with straining, and perhaps with the presence of mucus in the stools. This is followed by constipation, which may be so marked that the condition may simulate obstruction of the bowels. If the attack is very acute there is some fever, the temperature going up to 102° or 103° Fahr., due to the extension of inflammation to the peritoneal covering of the cæcum producing a local peritonitis. This also leads to marked quickening of the pulse which may be much accelerated. The stomach also sympathizes and a few attacks of vomiting are not at all rare.

These, then, are the symptoms of acute inflammation in the cæcal region. The affection is most common in young persons. It occurs very often in children, and often enough in young persons up to adult age, and it may occur in old persons.

Causes.—Impaction of the feces is a frequent cause of this inflammation. The bowel may be full of partially digested, crude, harsh material, and its coats are irritated. If, while the bowel is in this condition, some strain or bruise is received, or a violent cold is taken, this part may become the seat of inflammation. Habitual constipation is to be borne in mind as a frequent predisposing cause. The inflammation may be caused by a strain or a direct blow. It may also come from a severe cold, taken when the system is in a relaxed condition.

The course of the disease under appropriate treatment is towards resolution, terminating in from ten to twenty days. Not rarely, how-

ever, the inflammation goes on to suppuration. When this takes place, the symptoms change. The patient has a rigor, followed by sweating, the fulness continues, and it is soon recognized that a process of suppuration is going on. The abscess must be evacuated. If it is not evacuated externally, it will burst internally, and while it may open into the bowel and be discharged with safety to the patient, it may burst into the peritoneal cavity, causing death. It may in some cases lie for a long time in the cellular tissue, and gradually wear the patient out, causing death by exhaustion. Even when the inflammation terminates by resolution, as it did in this lad, there is a marked tendency for these affections of the cæcal region to leave behind them a state of weakness which disposes to relapse. A little thickening of the coat of the cæcum and of the pericæcal tissue is left with a greater tendency to accumulation of feces; the constipation continues, and from time to time, some slight cause, as a blow or exposure, will light up the inflammation, and the patient will have a fresh attack. I have seen this repeated as often as ten, twenty, or thirty times in the course of a few years. This lad has had no less than four or five attacks of perityphlitis since coming under our observation. These repeated attacks lead to a permanent thickening of the wall of the cæcum. I have seen it as thick as my finger, and the cavity so contracted as to scarcely admit the thumb. The cæcum, instead of being large, flexible, and elastic, was a rough, gristly tube, with a contracted, narrow, tortuous channel through which hardened feces could not pass, the bowel itself being fastened to the iliac fossa by dense adhesions. In this condition, the case becomes almost incurable. It is, therefore, excessively important that not only should the acute symptoms be subdued, but that we should also be satisfied that not a trace of trouble is left. The thorough treatment of all cases of typhlitis and perityphlitis is one of the most important lessons which could be impressed upon you. There is another danger in connection with these cases. Although the patient may appear to be getting well and the swelling subsiding, yet there may be some point outside of the cæcum where suppuration is going on, producing a small collection of pus somewhere behind the bowel, where it is not accessible. This may remain as a constant source of danger, and, as these fresh attacks

occur, it may burrow in various directions. I have seen such an abscess suddenly make itself visible in the lumbar region, or burrow down and come out through some of the openings of the pelvis, and appear at a distant point in symptoms of pyæmia.

Let us now examine as to the present condition of the patient. The belly is distended. Palpation reveals a well-defined fulness on the right side. This is found to fill up the hollow of the iliac fossa, and I can trace it downwards some little distance. This is not very hard. The part is tender even on gentle pressure. In an upward direction it extends not quite to the top of the iliac fossa. There is perfect resonance on percussion, showing that there is no accumulation of feces, and that there is not enough effusion to press the cæcum away and give an area of dulness.

This is a case of chronic perityphlitis in which the wall of the bowel has been moderately involved, giving rise to a chronic catarrhal inflammation, which is constantly forming mucus which appears in the stools. The walls of the bowel are weak and dilated, leading to constipation, so that in order to secure evacuations some laxative is constantly required. He is now almost entirely free from fever; the pulse is sixty-three per minute, and the tongue is moist and slightly coated.

A point of great importance in the study of these cases is the examination by the rectum. When I have an opportunity of speaking to you of affections of the vermiform appendix, and to call your attention to the great importance of making an early diagnosis in these diseases, which run an exceedingly rapid and fatal course, I shall point out to you that the only way in which we can hope to do this is by a thorough examination by the rectum, introducing the hand with the patient under the influence of ether, so as to be able to precisely locate the seat of inflammation. A careful examination of the rectum is a matter of extreme importance in many intestinal affections, and is far too little attended to. I shall frequently call attention to errors of diagnosis which may result from the neglect of this simple method of examination. This is an unpleasant duty, but at the same time it is an important one. I shall now make the rectal examination in the present case. I first examine the left side, so as to appreciate the curves of the pelvis. On the right side, I undoubtedly detect some fulness, which

is felt as low down as I can reach with the finger. When I press on the hardness in the iliac region, I do not feel any impulse communicated to the finger in the rectum. There is no fluctuation. This thickening in the right side is evidently due to pelvic cellulitis, which has extended from the perityphilitis. There is no evidence of suppuration. The result of the rectal examination confirms our opinion drawn from the study of the cæcum, and is negative as far as any indications for treatment are concerned. Where in the early stages of an inflammation in this region we are in doubt, it is exceedingly important to make the examination, not simply with the finger, but by placing the patient under ether and introducing the whole hand so that it may be carried up and feel the surface of the cæcum, the position of the appendix, and determine whether or not there is any formation of pus even if it be small, and guide us in deciding the question of opening the abdomen for the evacuation of the pus.

This boy has been sick so long, and has had so many of these attacks that it is evident that he must be cured without delay, or the condition will run into one of chronic thickening and contraction of the bowel, which is practically incurable. I propose to put him upon a course of treatment which will be maintained with great strictness, in the hope that further relapses will be avoided.

In the first place, he must be guarded from all atmospheric changes. Whenever a change of weather is threatened extra precautions should be taken. No matter how much better he gets, and if he is allowed to be out of bed his movements will be closely watched, and he shall be put to bed before the approach of an expected storm. The dress must be attended to. A belt of flannel shall be placed around the abdomen, so as to protect the affected zone. Constant counter-irritation must be kept up over the seat of thickening. This can best be done by repeated small blisters an inch and a half in diameter, repeated every ten days, in a line from the groin up along the fossa.

The diet must be regulated with care. I shall give him milk, which has been peptonized, so that there will be no formation of hard masses of curd which might accumulate in the cæcum. We shall also give light cereal preparations, such as fine grits. He can also have broths, soft eggs, raw oysters, and soft milk toast, but we shall avoid all articles which

will leave a bulky or hard residuum. The bowels must be kept regular. The use of laxatives is not desirable. I shall order him to have two or three times a week an injection of three ounces of sweet-oil at night, to be retained all night, and, if necessary, an injection of soap and water in the morning. The oil will lubricate the rectum, and will be drawn into the colon by aspiration.

Internally, I shall give the following, made into a hard pill:—

R. Ex. nucis vomicæ . . .	gr. $\frac{1}{4}$
Ex. belladonna . . .	gr. $\frac{1}{2}$
Argenti nitratis . . .	gr. $\frac{1}{6}$

This will be given two hours after food has been taken, so that it may be passed into the bowel with the digested contents of the stomach.

This treatment will be persisted in for some time. If we find that the hardness continues, and every now and then, from some trifling cause, there is increased soreness and pain, with a little feverish irritation, I am satisfied that our duty is to cut down upon the iliac fossa, and see in the first place whether there is any small abscess, and if there is, evacuate it. If there is no abscess, we should put in a drainage-tube and encourage discharge, allowing the wound to heal solidly from the bottom. As in these cases, where the disease proves chronic, the results are so unfavorable where the case is neglected, and, as it has been subsequently found that in many of these cases there was a small abscess out of reach of the fingers, I am in favor of incising these cases if they resist all other treatment. I think, however, that this patient will be cured by adherence to the strict course of treatment which I have indicated. I shall bring him before you at intervals of a month in order that you may note the progress of the case.

ORIGINAL COMMUNICATIONS.

MEDICAL JURISPRUDENCE.

BY HENRY A. RILEY, ESQ., N. Y.

IN a recent English case the question at issue was whether there was proper ground for the commitment of a person to a lunatic asylum, suit having been brought for damages for such commitment against the physician who signed the certificate.

The latter said that he had reasonable and

probable cause for believing the plaintiff insane, and an application was then made to compel a statement of his reasons for such belief. The court granted the application, and the opinion given will be of interest. The judge said: "The matter in dispute is that the plaintiff wishes to know the reasons why the defendant libelled and imprisoned him in a lunatic asylum. To this the defendant answers that he said, 'the plaintiff was mad because he was mad, and that he locked him up for the same reason.' It seems to me reasonable that the plaintiff should know the grounds on which the defendant formed his opinion as to his state of mind. Why should not the defendant state in writing the grounds upon which he acted? I confess I cannot see why he should not do so; he must have had some grounds, and in my opinion, the plaintiff ought to know them, in order that, if possible, he may be able to refute them. That being so, it is contended on behalf of the defendant that it would be oppressive and vexatious to order him to give such particulars, because it would be impossible to give them clearly, and they would be so difficult to express, that it would be necessary to give the whole of the defendant's brief and all the details of the case on which he relies. I do not agree with that contention. I think that these particulars are capable of being stated in a manner sufficiently clear to be useful. If they cannot be stated otherwise on account of the details involved in them, they may be given in general terms. On the other hand, if the defendant had plain, clear grounds for acting as he did, I fail to see why particulars of such grounds should not be given and stated as clearly as the circumstances permit."

The last Legislature appointed a commission "to investigate and report to the Legislature of New York, on or before the fourth Tuesday of January, 1887, the most practical and humane method known to modern science of carrying into effect the sentence of death in capital cases." This commission consists of Elbridge T. Gerry, of New York; Dr. N. P. Southwick, of Buffalo; and Matthew Hale, of Albany.

The sentiment which caused the appointment of these gentlemen is, of course, dissatisfaction with the mode now in vogue, viz., hanging, and a variety of substitutes have been suggested. A bill was presented to the Legislature a year or two ago which allowed the condemned

criminal to make a choice of the method of death, and if no choice was made, then hanging was to be considered the legal mode. This bill did not pass and has been dropped, we presume in favor of the present commission.

The Albany Law Journal not long since, in very vigorous language, expressed its entire disapproval of hanging. It said, "All the preparations for hanging are shocking and demoralizing. Sometimes the victim hears the noise of the hammers preparing the fatal engine for him. His death, at best, is lingering and curious, and morbid eyes watch his dying struggles. Sometimes the operation is inhumanly painful. When all is over curiosity hunters greedily strive for a bit of the rope or a chip of the gallows. The next day the newspapers have long and detailed accounts of the last awful scenes. All this is extremely demoralizing to the community. Executions ought to be more private, and 'reporters' ought to be excluded. The offenders ought to go out of life as noiselessly and mysteriously as possible consistently with the idea of public justice. When there is such an unfailing, instantaneous, and painless agent as electricity for instance, so easily and cheaply applicable, it seems that it might be utilized in the execution of capital offenders. We expect to hear a howl of derision at this suggestion.

"There is always a class of men who believe in making public punishment as painful and revolting as possible. Who yearn for the whipping-post, and probably for castration for those guilty of rape, and the like; but it is our experience that this is one of the lower classes whose passions are strong and need strong appeals."

The crematory at Fresh Pond, New York, has the proud satisfaction of knowing that it has burned the bodies of more persons than all the other crematories in the country, notwithstanding the short time it has been open to the public. The use of the crematory does not now attract the attention that it did at the outset, but very likely the patrons are as numerous as ever. One of such patrons, we believe, was the late Charles Cohn, whose will has been admitted recently to probate by the Surrogate of New York County. In this will Mr. Cohn says: "I want my body cremated without ceremonies and in the simplest and least expensive way. The ashes I wish either to be sprinkled around a tree or on a garden spot,

where the rains may mix my remains with the soil or the winds disperse them otherwise." Mr. Cohn made himself unpopular with his heirs by cutting them off without a cent, but to show that he had not forgotten them, he placed his photograph in the envelope containing his will, with the words on the back, "My congratulations to my heirs."

A correspondent of the Albany Law Journal gives the following extract from the will of another cremationist: "It is my will that my body be cremated as soon after my decease as practicable, and that my ashes be divided into as many portions as I shall leave children me surviving, and I direct that thereupon one of such portions shall be given to each child of mine who shall survive me. I request my said children to tenderly deposit the portion of my ashes which they may receive upon such distribution in suitable receptacles of gold or silverware to be prepared especially for that purpose, which, with their contents, I trust they will ever lovingly cherish as souvenirs of their departed parent."

A Massachusetts court has just decided that it is constitutional to enact laws authorizing courts and magistrates to award to the overseers of the poor the custody of children found to be neglected by their parents, and growing up without education or salutary control, and in circumstances exposing them to lead idle or dissolute lives. The commitment by a magistrate is not conclusive, however, and the parent has a right to show that the cause for the commitment does not exist, and that the welfare of the child will permit of his discharge from custody.

There have been some recent cases of interest in regard to public health, and especially concerning the great question of city sewerage. In one case in a Brooklyn court, it appeared that a system of sewerage was adopted which was sufficient for the needs of the district at first, but which afterwards became inadequate, and was known to be so. Complaints were made about it, and there were frequent overflows. In one of these the property of the plaintiff was damaged and he sued the city. In this case the authorities were held liable. In another case, in Baltimore, the officials used a flowing stream as an outlet for a sewer, and had entire control of it, but it was not properly inclosed and the water backed up, and as a consequence overflowed and caused damage.

The defense was that it was a flowing stream and the city was not responsible, but the court decided that the defense was untenable, and payment must be made for damage inflicted.

A NEW IMPROVED TROCAR AND CANULA.

BY JOHN S. MILLER, M.D.

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THE frequent occlusion of the canula by intestine or omentum in the operation of tapping the abdominal cavity, has suggested the device shown in the following cuts. The stoppage generally occurs when about a pint of fluid has been withdrawn, and various manoeuvres are resorted to, such as the endeavor to float away the obstruction by changing the patient's position, or the dangerous one of introducing a probe through the canula, and generally without success.



The device to which reference has been made, is a smaller and longer canula introduced into that already in position in case there is a cessation of flow. It is blunt and provided with two long fenestra. In the latter are springs which expand and push aside the obstruction on emerging from the original canula, and which are so solidly soldered as to offer no danger of breaking off in the abdominal cavity. In reply to the query whether or not the gut can become incarcerated and wounded in the springs, it may be stated that in several operations no such accident has occurred, nor were efforts successful to bring such about upon the recent cadaver. The instrument can be used with any trocar and canula above calibre 16, French.

The instrument is manufactured by Charles Lentz & Sons, No. 18 North Eleventh Street, Philadelphia.

It will pay you to place your advertisement in THE MEDICAL BULLETIN. It is now the largest and best medical journal published for \$1.00 per year, and its circulation is increasing very rapidly.

SOME ADDITIONAL CAUSES OF SUBINVOLUTION.*

BY T. V. CRANDALL, M.D., PHILADELPHIA.

I APPROACH this subject with a degree of embarrassment, because of the inability of the best recognized modern authorities to agree as to nomenclature, cause, or pathological condition. All writers acknowledge its frequency, and many accurately describe the patient's sufferings. All have a large list of remedies.

It is my desire to speak of that form of subinvolution or chronic metritis, or areolar hyperplasia, arising from childbirth and abortions, and pass by this condition when caused by, or accompanied with, fibroid tumors, polypi, and kindred abnormal conditions mechanically producing it. Indeed, the long list of possible causes are more or less speculative, and the literature on the subject up to about fifteen years ago is not abreast with the present advances of pathology.

I desire to speak from clinical and anatomical observation, as the pathological condition is undetermined, and not enough study in the right direction has been given to this subject by pathologists.

Omitting a large list of causes as given by text-books, is it not a fact that clinically we find subinvolution following the puerperal condition, abortions, and miscarriages?

Immediately following delivery, provided it has been a case of "hands-off," the waters having dilated the os, no traction on the trunk after the head is delivered, the uterus having been permitted to discharge the placenta, no rupture of cervix or perinæum, and what follows? Subinvolution? No; another and another accouchement, until in time a baker's dozen.

Just at this stage the uterine contractions continue for a period of eight days or more; the object, to express from the parietes liquids with which the walls are still engorged after delivery. This lochia contains one-third red globules, the balance white globules and epithelial cells, grayish molecular granules and granulations of fatty matter.† Here we have in the walls of the uterus this discharge, which is "humoral engorgement," and contains ele-

ments for areolar hyperplasia. Now, if, instead of the normal condition of labor which I have described, some condition exists, or is produced, causing an injury to the uterus, vagina or perinæum, a laceration of the cervix, either subsequently perceptible or not, or rupture of the vagina, or a lacerated perinæum, the nerves of and about the uterus receive a *shock*. The contractions cease, the lochia is partly or entirely suppressed; there will be more or less of bright blood for weeks, but the fading and changing phenomena of the lochia are not present, the engorgement of the uterus remains, and we have a mild metritis, which passes into chronic metritis or subinvolution in the first stage described by Scanzoni.

"The uterine tissue is infiltrated with blood, serum, and fibrin, the organ in a state of engorgement, œdema, the consequence of active and passive hyperæmia. It is enlarged in volume, altered in shape, reddened, and more or less sensitive on pressure, soft and doughy to the sense of touch. Long-continued venous hyperæmia leads with comparative infrequency to induration. Although intercurrent inflammations and exudations and new formations of tissues may produce that effect, this stage cannot be invariably viewed as of an inflammatory character; these enlargements of the uterus are frequently examples of the nutritive disturbances commonly observed in the organs in consequence of long, continuous, venous hyperæmia." This first-stage theory of Scanzoni is ably supported from clinical observations by Byford.

"Insufficient post-partum contractions of the uterus easily lead to the gradual development of chronic metritis."—*Mayerhoffer*.

"The condition termed subinvolution, where the uterus remains too large after childbirth, is due to faulty nutrition; the reparative powers having been *checked* in the process of removing the old material."—*Emmet*.

"This condition is due to many causes, among which puerperal inflammation is only counted as one."—*Schroeder*.

"Chronic metritis usually results from an extension to the body of the womb of an inflammation of the cervix."—*Bennett*.

"By chronic metritis is meant such tissue changes in the substance or parenchyma of the womb as are brought about from a previous inflammation or a persistent hyperæmia. In its early stages it seems to be characterized by

* A paper read before the Thirty-seventh Annual Session of the Pennsylvania State Medical Society.

† Leroux.

passive congestion, and by infiltration of a sero-sanguinolent fluid."—*Goodell.*

"It is by the same mechanism that laceration of the perinæum becomes a cause, first of subinvolution of the vagina, then of the uterus itself."—*Mary Putnam Jacobi.*

I have made these quotations to show that when Scanzoni formulated his ideas (1863), he nearly approached the true theory as to cause, and I believe, with the advantages of the American literature of the present day on cervix and perinæum lacerations, and partial lacerations of the body of the uterus, he would find sufficient cause in these accidents for chronic metritis and subinvolution.

Simpson says that evidence of a certain degree of laceration is given by almost every careful autopsy of women after delivery, whether assisted or not during labor. Emmet says that at least one-half the ailments among those who have borne children are to be attributed to lacerations of the cervix. Goodell says that at least one out of every six women suffering from uterine trouble, has an ununited laceration of the cervix.

Injury to the upper third of the cervix or body of the uterus will be doubted, or even not suspected, where a speculum examination shows a perfect os. Two years ago I saw a case in the practice of Dr. B. J. Rudderow, where a laceration had occurred involving the posterior wall above the vaginal junction, and six weeks after delivery I was called to repair the injury. When the patient was in the Sims position, and the speculum introduced, I was about to measure the uterus, when the sound by its own gravity was nearly lost in the abdominal space through this opening. Drs. L. K. Baldwin and Rudderow each confirmed my diagnosis. I repaired the injury as far as possible, and no unpleasant results came from the operation. She died subsequently of double pneumonia, caused by exposure to cold; an unmistakable case confirmed by a consultation of physicians. Post-mortem refused. A second case of rupture of the wall of the uterus with a perfect cervix is now under observation. This lady at thirty-five has five children. Six weeks previous to my first visit she was delivered with instruments, all her previous labors having been natural, without instruments. The uterus measured five and a half inches, and in exploring with the index finger I found a laceration in the posterior wall. I asked Dr. Goodell

to see this case as a matter of great interest, as they are most all fatal.

If, then, from shock to the uterus, the result of contusion or laceration, the contractions cease, or from a degree of soreness succeeded by an inflammatory condition, then the removal of the uterine detritus is checked in proportion to the degree of congestion or inflammation set up in the neck and spreading to the womb. The elasticity of the muscular fibres is not exhausted, but the contractility ceases or is reduced in proportion to the injury. A wounded muscle will not contract. Tait says that the majority of cases—one might say ninety-nine cases in one hundred—of chronic metritis are contracted by, and directly due to, subinvolution of the uterus after labor or miscarriage. Contraction arrested, a low degree of metritis produced, and no treatment instituted, the patient passes to Scanzoni's second stage of subinvolution or chronic metritis, and it seems to me only nominally differential. The second stage is described as induration. Connective tissue replaces the elements which are destroyed by chronic inflammation. The soft tissues become infiltrated, and the vessels are narrowed or obliterated by the contraction of this new tissue, which is pale, tough, and so hard that a knife cuts it with difficulty. It is not my purpose to quote authorities to prove or disprove theories; these you will find ably discussed by Drs. Jacobi* and W. W. Jaggard† quite recently.

In the same line of thought and argument as to cause, I would review some of the methods of cure. We find an enlarged uterus longer than it should be, too heavy, and more or less of prolapse. The object is to lighten it, reduce inflammation and remove the sufferings of our patient. If there is an early detection of laceration, and the first stage of subinvolution, an early operation will cure both. We then deplete while the uterus is soft. If an old trouble of similar character, there is no greater relief obtainable than by a well-done cervix operation. I have recorded measurements in one hundred and fifty operations, and they range from three to six and a half inches. One case was an hypertrophied cervix and body, measurement six and a half inches—one and a half inches removed one year after confinement. By supuration and depletion, application of iodine

* American Journal of Obstetrics, August, 1885.

† A System of Medicine. Pepper, Vol. IV.

compounds, etc., in one year the uterus measured plus three inches. We cannot always obtain after-measurements, but as far as possible I have done so with gratifying results. In old cases, amputation gives better results. Many look upon this as a formidable operation. Dr. Thomas reports: Hugieur, thirteen operations, no deaths; Sims, fifty, one death; Simpson, eight, one death; his own, fifty, and one death; while Dr. Byrne with the galvano-cautery, operated largely, and no fatal result. It is not necessary to remove a large portion of the neck to obtain the desired result. The prolonged suppuration (two weeks), the free hemorrhage, starving the uterus by severing blood supply, all set up an action which shortens and consolidates the womb, and cures subinvolution. The alterative applications to the endometrium should be prolonged at intervals for months, but the ordinary applicator with cotton is a delusion. The internal os strips it of medicament, the mucus of the uterus coats it, and very little good comes from such treatment. For years I have used a non-corrosive, intra-uterine syringe with perforated sides, wrapped in cotton. I saturate the cotton by ejecting enough of the contents of the syringe, then after insertion eject a few drops, and with a side-motion remove it. This is not an intra-uterine injection; there should not be enough of the fluid used for that. The alterative effect of iodine needs neither extolling nor explaining; the iodized chloral-phenol of J. P. Thomas is the best for this trouble, but should be reduced gradually after the first month. If there are fungous growths on the mucous membrane, they should be removed with the curette. The history as to hemorrhages will determine this point. Another important factor in producing subinvolution, first of the vagina, then the uterus, is a torn perinæum. We know the frequency, and the sensitive, nervous structure; this should be looked to as a cause, and restored as a remedy, though not with such immediately gratifying results as in the cervix operation. The same can be said of injuries to the walls of the vagina.

1928 Spring Garden Street.

THE IMPORTANCE OF ALBUMENOID DIET.

BY WILLIAM R. D. BLACKWOOD, M.D.,
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MANY people prefer quantity to quality, and this is particularly true with reference to their daily food. That most persons make the least of their chance in selecting their marketing, and throw away money on fashionable cuts of meat when more nutritious material is available at lower prices is notorious. Sir Henry Thompson says, in the *Popular Science Monthly*: "I have come to the conclusion that a proportion amounting, at least, to more than one-half of the disease which embitters the middle and latter part of life among the middle and upper classes of population, is due to avoidable errors in diet." And again: "True indigestion, as a manifestation of a diseased stomach, is comparatively quite rare. Not one person in a hundred who complains of indigestion has any morbid affection of the organs engaged in assimilating his food. As commonly employed, the word 'indigestion' means, not a disease, but an admonition." Bad as defective selection or unskilful preparation of food is for those in health, it is infinitely worse for the invalid and for growing children, and if more attention was paid to regulating the diet of our families than is usually done by general practitioners, drugging would be less prevalent, and we could compete with homœopaths on their own ground, for it is the careful attention to diet that insures their success, and not at all the potency of their microscopic attenuations, which are equally valuable whether administered, "exhibited," or smelt.

Physiologists are agreed that a perfect food should contain about fifteen grains of carbon to one of nitrogen, but this proportion exists in no one article of diet. To obtain it, therefore, a variety of food must be eaten, and this variety cannot always be procured, nor can all persons indulge in it without overtaxing the digestive organs.

As an aid to nutrition and to digestion, one or other of the numerous concentrated foods, as prepared by manufacturing chemists, are at times very acceptable, and, in enfeebled states of the system, they are often better than ordinarily prepared aliment. I have occasionally, in papers in this journal, adverted to

THREE HUNDRED AND THIRTY-FIVE!—THE BULLETIN received three hundred and thirty-five new subscribers during the month of September, 1886.

such preparations, and I now speak of the article known as "Emerson's Albumenoid Food," which is, I believe, intended more for infants and invalids than for others, but my experiments with it show that it is of value for acute cases also. If we feed people who are in other respects healthy, but who have slow digestion, with something that is *quickly* and easily absorbed, and which is at the same time nutritious, much is gained. Now the country is flooded with foods more or less peptonized, and good as many of these are, they do not always meet the indications alluded to. Some of them (representing meat extracts) are illy borne in those of constipated habit; they require too much time for complete absorption, and, as nutritives, no matter how intrinsically valuable, are unavailing whilst in the stomach or intestine (in fact they are practically outside the circulation), this class is at fault. Meats require *complete* peptonization before passing into the circulation, and Schmidt-Mulheim has shown that in one hour after eating 50.38 per cent. was not dissolved in the stomach, whilst only about 2.26 per cent. of albumen remained unabsorbed. The intestine contained three times as much undigested muscular fibre as it did albumen, hence nutrition under such circumstances was evidently favored by the albumenoid food.

Another class of prepared foods is the malted products. Just now these articles deservedly are in favor, and in the instances of those peptonized during fature, they are invaluable. They are particularly adapted to disorders of childhood. In the cases presenting flatulence, or a tendency to fermentation in adults, they are not well borne, and troublesome diarrhoea is sometimes induced by persistent use of them. When purely vegetable in composition, these foods lack the azotized element *par excellence*—a serious defect, because a due admixture of nitrogenous vegetables (cereals and fruits included) and fatty aliment is required to maintain health, or to restore it if below par.

Nitrogen does not exist in a digestible form, except in an albumenoid. The principal albumenoids are albumen, found in eggs and the serum of the blood; fibrine, found in meat; caseine, found in milk; legumen, found in vegetables, and albumenoids, found in the cereals.

Casting about for something in itself nutritious yet readily assimilated, I have notably

filled the want with the Emerson preparation. I am testing it in both hospital and private practice, and in the latter class it has served nicely in rheumatic fever, in phthisis, in chronic indigestion, in the constipation of pregnancy; and, although not at all a canonical article in such cases, it is apparently better than any other material in a case of albumenuria from granular kidney. With children it acts well, but fortunately, or unfortunately, I have run behind in my cholera-infantum list this year, still, at some other time, I hope to see how it will succeed in such cases. More might be said if space permitted, and at another time the results hereafter reached will be given.

The annexed analytical table shows at a glance why the food is valuable:—

	PER CENT.
Water	5.50
Ash (containing 1.39 per cent. Bone Phosphate of Lime)	2.32
Total Albumenoids	19.25
Fat	5.49
Sugar	41.67
Starch (Gelatinized)	25.77
	100.00

It is noticeable that the albumenoid, the oily, the sugar, and the starchy elements are represented in a fair proportion, none are present in excess, and the absence of any medicinal agent is a further advantage. No nausea or fullness has shown itself in those employing it, although such symptoms are not uncommon with many prepared foods.

My intention is not to substitute ordinarily digestible diet by "albumenoid food," but to either add it to the usual meal in convalescents, or to use it until the digestive apparatus is abundantly able to do its normal work. Just as a stimulant braces up the patient, so will a good albumenoid preparation arouse nutrition, with the difference that a stimulant of itself adds no *real sustenance* to the blood whilst albumenoids do. In attaining this end we not only gain strength, but we enable patients to take therapeutic remedies which they otherwise are incapable of using. Again, after the crisis of a severe fever or long illness, it becomes desirable to feed frequently, yet moderately—to coax nutrition—and here we achieve our end nicely. Nothing, so far, has met my purpose more happily, and I know that judiciously used by others, the Emerson food must obtain equally gratifying results.

One other point is noted: For some time past coca preparations have been fashionable—for fashion has crept into medicine at last. To poor people coca is a-burden from its cost, and any substitute is desirable if just as good. In fully half such cases as coca is prescribed for, albumenoid food is, if not actually better, at least readily exchangeable, and thus the objection as to expense is met. Further, it is certain that too much alcohol is taken by convalescing cases under the coca plan, and too little thought is taken on this point. The great *sustaining* power of this new drug is overstated. You cannot do with less food under its use, and serious renal complications in scarlatina and other exanthemata are traceable to the careless use of medicinal wines to my own knowledge. It is better to go slowly at times, but coca and cocaine have traveled at express speed and met with unnecessary wrecks in consequence.

My time, and the demand of THE BULLETIN for brevity, compel me to defer illustrative cases until another number. I trust the readers of this journal will try for themselves the virtue of aiding nutrition as I have pointed out, and let us hear from them.

246 NORTH TWENTIETH STREET, PHILA.

EPIDEMIC DYSENTERY.

BY O. L. DALES, GRAND RAPIDS, MICH.

IN perusing the ever-welcome MEDICAL BULLETIN I observed in the Therapeutic Notes some valuable suggestions for the treatment of dysentery. Having had an extended experience in the treatment of the epidemic variety of that disease, I venture to give the plan of treatment which I pursued. When called to a case, and finding the following symptoms present, tormina, tenesmus, mucus, and bloody stools, great tenderness in left iliac region and elevation of temperature, I directed hot fomentations to be constantly applied over the lower portion of the abdomen, and gave the following:—

R. Tr. opii 3vi.
Tr. catechu 3ij.
Aqua menhth,
Syr. acacia 3ā q.s. 3vj.

M. Sig.—Two teaspoonfuls in water every two or three hours.

R. Bismuth subnit. grs. xx.
Every four hours.

For the pyrexia:—

R. Quinia sulph. 3j.
Antipyrine 3j.
Acid tannic grs. xx.
Syr. simplex 3iv.

M. Sig.—Two teaspoonfuls every three or four hours as required.

After the urgent symptoms were arrested a full dose of castor-oil or magnesia sulph. was directed to be taken, there being a tendency to fecal accumulation above the seat of inflammatory action. Of twenty-seven cases treated in this manner twenty-five made a rapid recovery, and were convalescent in from three to five days.

SOME OBSERVATIONS DURING TWO YEARS' RESIDENCE AT COLORADO SPRINGS, COLORADO.*

BY J. T. ESKRIDGE, M.D.

I WILL endeavor, in as brief a space as possible, to make some practical remarks concerning Colorado Springs as a health resort for consumptive patients especially. For what I shall have to say of the climate I shall rely mainly on my own observations, made during the two years that, as an invalid, I have resided there. In regard to the effects of the climate on phthisis, I will try to sum the results of the experiences of the principal physicians of the place, and give them, together with what I have observed. I am not ignorant of the fact that you can find over-painted descriptions of Colorado climate. So you may of every other climate that is supposed to have a beneficial effect on lung troubles. To such a degree have the climatic virtues of different places been lauded, that disinterested physicians have come to have but little more confidence in the greater portion of the statements made in articles written by physicians who reside and practice at these various health resorts, than they have in the exaggerated accounts of the healing powers of some patent medicine; and, as the nostrum is praised simply because it pays, so physicians do not altogether escape suspicion, or even censure, of being influenced by mercenary motives in their comparisons of the relative advantages of different climates. The truth is, it is very difficult not to allow one's self not to become over-enthusiastic concerning

* Read before the Philadelphia County Medical Society, September 22, 1886.

the merits of a place in which you find so many who were failing rapidly before leaving their homes, able to enjoy life, live in the open air, and frequently resume business again. That I may escape any suspicion of being influenced by a mercenary motive in writing this paper, I will state, that since I have been at Colorado Springs, I have done no general practice, nor do I intend to resume it there. From time to time, I have had cases of lung trouble referred to me by Eastern physicians, but I have invariably refused to attend them. I am glad to have this opportunity to say that there are a number of good physicians residing there. I have never before been in a place of its size where so much intelligence and talent in the medical profession was to be found. The greater portion of the physicians who reside there have been compelled to go to Colorado on account of their health. Most of them are graduates of some of the best medical colleges East. I am sorry to have to say that you will also find a number of irregular physicians there.

Climate.—I wish to remark, in prefacing this subject, that the longer one has resided in Colorado, the less certain he is regarding weather prognostics there. For convenience sake, the year may be divided into two seasons, the wet and the dry. The former usually begins in April and ends in September or October. From October to April, as a rule, there is no rain. During a large portion of the wet season it is the rule to have daily showers in the early part of the afternoon, lasting from half an hour to an hour, the remainder of the day being clear. In the latter part of June and the early portion of July of the present year, there was a dry spell of several weeks' duration, with almost no rain at all. Most persons who visit Colorado are prepared to expect the daily showers during the rainy season, but what they are not prepared for, and what not infrequently makes many suspicious of the reputed dryness of Colorado weather, is the occurrence, once or twice annually, of rainy spells of weather, lasting two, and sometimes, three days. During a portion of these times it rains as hard as I ever saw it along the Atlantic coast. So much for the rainy season. I have seen it stated that no rain falls there from the last of October till March; yet, during last winter I remember two light showers. They did not last long, nor did much water fall. Some persons who had resided in Colorado Springs for several

years, told me that they never had seen rain there before during the winter months. I should not consider these showers of sufficient account to deserve mention, were I not trying to give as accurately as possible, my observations of the weather there for the past two years. No rain fell in the winter of 1884-85. During the winter repeated light snows fall, but they do not lie on the ground long, and evaporation is rapid and the soil porous, so that they disappear without leaving the ground damp for more than a few hours after the snow is gone. While the snow is rapidly thawing in the hot sun, but little water is found on the ground, so that the days and weeks of terrible sludge so commonly experienced in many portions of the country are almost, if not entirely, unknown in Colorado Springs. It is in the cool, dry weather that the air has the most invigorating effects. It sometimes may be said to be crispy and exhilarating. The warm season is much shorter than we find it in Philadelphia. Spring is late, in fact, this season seems to be largely dispensed with, and the change from cool, wintry weather into mild summer heat is not uncommon. The years that I have been in Colorado, cool weather has begun the latter part of August, although it is frequently quite warm in the middle of the day, until late in September or the beginning of October. The warm season is but little over two months' duration. During this season the thermometer in the shade may rise from 90° to 100° Fahr., but, as a rule, only for a few days in succession. The summer just past seems to have been an exception in this respect, for we had a spell of one or two weeks of quite hot weather. During August of 1884 (the time when I first reached Colorado Springs) and the summer of 1885, I did not experience a night that one or two blankets were not necessary. In the hot, dry spell of July of the present year there were several nights that I could not endure a single blanket. From my experience, I should say that it is the exception not to find comfortably cool nights throughout the summer in Colorado. Evaporation is so rapid that the heat is much less oppressive than we find it at the same temperature along the Atlantic coast. I never have found any difficulty in keeping comfortable on the hottest days whilst I was sitting quietly in the shade. The weather rarely gets very cold much before Christmas. Last winter no very cold weather was experienced until the first of January. The

coldest weather occurs during January and February. The average temperature during these months is not very low (from 25° to 30° Fahr.), but occasionally the thermometer drops to 20° or 30° Fahr. As the heat is less hard to endure, so the cold is less chilling and piercing in a dry than in a damp atmosphere. One will have to visit, in the winter, Colorado or some other place with a similar climate, and experience for himself, before he can realize fully, the difference in temperature between the shade and the sun, even on the coldest winter day. During the winter, with the sun shining brightly, a thermometer exposed to the direct rays of the sun and protected from the wind will rise to 100° to 110° Fahr., whilst the temperature in the shade, probably not four feet distant, will be below 30° Fahr. On several occasions, in midwinter, while I have been sitting in the sun, I have been compelled to use an umbrella for protection, the shade temperature at the time being sufficiently cold to freeze. One of the great advantages of Colorado climate in the winter is the amount of time that invalids can be in the open air, although they may not be able to take much exercise. During the month of February of 1885, there were only three days that I was unable to sit in the open air with entire comfort from about 10 A.M. to 3 P.M. The hours of sunshine in Colorado, during the fall and winter, double, and probably treble, those along the Atlantic coast. The meteorological records, where three observations were made daily, show only three cloudy days for some winters. The observations, I have no doubt, are literally correct, but somewhat deceptive, if we were to understand by them that all the days but three of an entire winter were bright and sunny. At the hours when the observations are made the sun may be shining, and twenty minutes after it may be cloudy, as it frequently is. These changes the records do not show. Observations which, when completed, will show the hours of sunshine each day for the entire year, are being made now at Colorado Springs, by means of the sun thermometer. I admit that an entire cloudy day, during the winter and fall is rare, but there are a number of raw and partially cloudy days that are too cold and disagreeable for invalids to be in the open air, unless they are strong enough to exercise sufficiently to keep themselves warm. Besides, there are some windy days that keep the weaker

invalids in doors. A few words in regard to sudden changes of temperature. I have not infrequently seen it stated by physicians, that in selecting a climate for consumptive patients we should choose one that is dry, free from high winds and great and sudden temperature changes. If you will reflect, you will realize that where there is but little moisture in the atmosphere there can be but a correspondingly small quantity of the solar heat retained by it, so that after the sun has been shining for a number of hours, and sets, or is hidden suddenly by thick clouds, there must be necessarily a sudden fall in temperature. The sudden changes in temperature may be attended by considerable wind. So common and sudden are these changes in Colorado, during the spring months especially, that no one who is prudent travels far from home or shelter without being prepared for such emergencies. You will find that when you have decided that your patient will do best in a dry climate, you must see to it that he is prepared by a sufficient amount of strength, and good warm underclothing, to endure sudden changes of temperature, if he expects to live much in the open air throughout the year. Of course, if a patient is careful to always be where he can readily obtain shelter, he may not experience much inconvenience from the variations in temperature. Another point: A place that has a dry climate with a loose, porous soil, must, of necessity, have considerable dust stirring during the windy days. A dry climate with a mild equable temperature is a thing that does not exist. Again, in high altitudes the air is more rarefied than at sea-level, and, in consequence, a greater amount of breathing capacity is necessary for a person to breathe with ease and comfort. For the reasons that I have stated, consumptive patients, with little breathing room (unless it can be increased), or in the last stages of this disease, almost invariably do badly in dry, mountainous regions, and die sooner than they will at low altitudes.

The question is often asked, How are persons in apparent health affected on going to an altitude of six thousand feet? I do not believe that persons in a good state of health experience any unpleasant sensations if they are careful not to exercise much on first reaching such an elevation, but the majority of persons visiting Colorado often make the mistake, on first arriving there, of exercising as much, or even

more, than they were accustomed to do at sea-level. The consequence is, that many such are troubled with irritable heart, shortness of breath after walking, and, what is more common, especially in persons beyond the age of forty, a full sensation in the head, a dull feeling in the ears, with some lessening of the acuteness of hearing. In about two weeks such persons, if they have not continued to take too much exercise, apparently resume their normal condition. I have made a number of observations on the acuteness of hearing in persons who have lived some time in Colorado, and these have led me to believe that this sense is not so acute as we usually find it in persons living in a damper climate. This will be easily accounted for, when we study the effects of the climate on exposed mucous membranes. These are, briefly, dryness, hyperæmia, inflammation, and thickening. The dust, wind, and dry atmosphere undoubtedly are the potent agents in producing these changes. Conjunctivitis, nasal, and naso-pharyngeal catarrh are very common. As a rule, there is not much discharge, the catarrh being of a dry, irritative character. The inflammation usually extends into the Eustachian tubes, and involves the middle ears. The larynx does not escape, and an occasional hacking cough is not infrequent in persons who are otherwise apparently well. From what I have gleaned from the experience of other physicians, as well as what I have observed, I think that all catarrhal affections of the air passages attended with much discharge are benefited, usually, on going to Colorado. My experience has been—and this is in accord with that of most of the physicians with whom I have conversed on the subject—that dry, irritative catarrhal conditions of the upper air passages, and of the middle and external ears, are made worse by residing in Colorado. It seems to be the almost unanimous impression with physicians whose opinions are entitled to consideration, that acute inflammations are sharper, and run a more rapid course, with, I think, less tendency to chronicity, than what we find of the same troubles at sea level. The physician who is sending patients suffering from phthisis to Colorado is desirous to know what cases most probably will do well there, and what ones he ought not to send. In my opinion, no positive information that will avail in every case can be given. Some, apparently the most desperate, do well,

and, on the other hand, others which he may have many reasons to believe will be greatly benefited, grow steadily worse, or fail to improve. In trying to give some information that may help the physician to decide, I shall ignore most of the different varieties of phthisis as usually classified. I do this mainly because phthisis is studied clinically rather than pathologically at most health resorts. It must be exceedingly rare that a *post-mortem* examination can be obtained on phthisical cases that die at Colorado Springs, for I have not been able to witness one there. Before endeavoring to specify certain classes of cases for Colorado climate, I wish to state that the physicians there are unanimous in their testimony to the fact that a prolonged residence causes an increased expansion of the chest. I am informed by some of the most careful that the circumference of the chest, on full inspiration, increases from one and a half to two inches during the first year. I think that I am justified in saying that consumptive patients, in the last stages of the disease, especially if weak and nervous, or those who have in addition to their lung trouble an irritable, weak heart, due to valvular lesion or a weakened heart muscle, should not be sent to Colorado. An irritable heart caused by poor nutrition rapidly passes away as the general health is improved. Theoretically, there are two classes of cases that should not be much benefited, if at all, by residing in Colorado; one is plastic bronchitis, the other fibroid phthisis. Of the former, I know of only one physician who has a case. It has not been under his care long, but apparently it is doing well. It is well known that patients suffering from fibroid phthisis may live a long time in damp climates and at low altitudes, especially if the climate is mild. But they do not get well; neither do they in Colorado. There they live comparatively comfortable for a number of years, taking much out-door exercise. The quantity of expectoration is greatly lessened, and its character improved, but increase in fibrous tissue goes on. From the irritative nature of the atmosphere there, we should expect that the increase of fibrous tissue would be more rapid than in a milder and damper climate. It is difficult to say whether the benefits derived from the lessened quantity of secretion, the aseptic condition of the atmosphere, and probably less tendency to bronchiectasis, do compensate for the irritative effects of the

atmosphere. I have been informed by one of the best and most experienced physicians of Colorado Springs, that he never has known a case of fibroid phthisis to terminate there by the development of tubercles. What the climate seems to offer in these cases is comfort, or amelioration of the effects of the disease—not a cure, and probably not as long a period of life to the patient. I have now to consider cases for which, if other things are favorable, there is little doubt about their being benefited by the climate of Colorado. The early hemorrhagic cases appear to do the best. It is almost, if not the unanimous opinion of the physicians there, that the climate of Colorado is not only not productive of pulmonary hemorrhage in phthisis, but that these hemorrhages are less frequent in a given number of cases than they are found to be along the Atlantic coast, or in the States near the great lakes. I wish to emphasize the fact that these cases must lead necessarily a very quiet life during the first period of their residence in Colorado. It is obvious that if a case that is liable to bleed on slight exertion were to go there and exercise much before the ulcerated portions of the lungs had healed, hemorrhage would result, and probably to a greater extent than it would have done from the same amount of exercise at sea-level. The tendency for ulcerated surfaces exposed to an aseptic atmosphere is to heal, and for this reason hemorrhages in the early stages of consumption are arrested. I have observed that pulmonary hemorrhage is rare there in persons who are prudent. In nearly every instance where pulmonary hemorrhage has occurred—and my own case is not an exception—the patient has had himself to blame for the bleeding. I will say nothing of the influence of the climate and altitude on the production of pulmonary hemorrhage in consumptive persons whose lungs contain large cavities, and who are in the last stages of the disease, for such cases should not be sent to Colorado. The effects of the dryness and aseptic condition of the atmosphere are clearly seen in lessening the secretion in cases where expectoration is abundant. Bronchial phthisis and the so-called catarrhal pneumonias do well. All those cases of phthisis in the incipient stage, provided the temperature is not too high, and the decided fever process is not kept up too long, improve rapidly. Persons suffering from phthisis may have a moderate rise of tempera-

ture, extending over a prolonged period, and yet improve in Colorado. The fact that a person has a small cavity in the lung should not prevent his going to a high altitude, provided there is a large portion of healthy lung, and the patient is not too greatly reduced in strength. All those cases embarrassed by conditions favorable for the development of tuberculosis, as indicated by heredity, poorly expanded chest, anæmia, loss of flesh, and often extreme weakness, usually receive great benefit from a prolonged residence in Colorado.

In this connection, I wish to say a few words concerning heart troubles as influenced by the climate and altitude at Colorado Springs. We are told by some writers that all heart affections are increased by the altitude there. To suppose that because a person has a valvular lesion of the heart, he, in consequence, will be unable to live comfortably at an altitude of five thousand or six thousand feet, is an error. I have seen a number of cases of valvular lesions of the heart there, the physicians having been kind enough to allow me to study their cases. I know of a few who have valvular lesions, and who work daily, without experiencing any difficulty. One of these is a poor woman, who works very hard, and is not aware of her heart trouble. One patient of Dr. T's has well marked mitral regurgitation, and suffers from shortness of breath and cardiac asthma, when at Colorado Springs, but when she returns to her husband's ranch in the mountains, at an elevation of about eight thousand feet, two thousand greater than that of the Springs, she feels comfortable. I certainly should not advise any one to go to Colorado for the cure of heart trouble, but when one is compelled to go there, the fact of his having a little roughness at one of the cardiac orifices will not be of itself a positive contraindication to his going. Cases of cardiac degeneration and enervation are the ones that suffer in Colorado, and in these the altitude may prove fatal. So long, then, as a case of valvular lesion of the heart gives rise to no discomfort, the compensatory hypertrophy being sufficient to compensate for the leakage or obstruction, there will be no difficulty, probably, in living at a moderately high altitude. But as soon as the dilatation is greater than the hypertrophy, and the heart muscle begins to weaken, will a valvular lesion be a great obstacle to living in Colorado. Persons affected with fatty degeneration of the heart should

avoid high altitudes. Irritable hearts, due to a highly sensitive, nervous system, bear exercise very poorly there. Irritable hearts, dependent upon weakness which is removable, do well.

It may be desirable to say a few words in regard to how invalids are affected on first going to Colorado. From what I have learned through the experience of other physicians and from my own observations, I do not believe that persons who are not extremely weak experience any unpleasant sensations. Invalids who go there and exercise too much soon after their arrival, as their feelings often lead them to do, soon begin to feel tired, and, perhaps, short of breath. Should a consumptive patient on reaching Colorado be attacked with spells of shortness of breath, without having exercised, it would be prudent, nay, urgent, for him to get away as soon as possible. Physicians, on sending their patients to Colorado or any other high altitude, should impress upon them the necessity of living very quietly. I am not exaggerating when I state that many cases are made hopeless, annually, by too great and too violent exercise. Horseback riding is for the select few only. Long walks and mountain climbing should not be indulged in for the first year, nor afterward, without the advice and consent of a good physician. It is not infrequently the case that one meets with persons who are quite weak with pulmonary trouble, and who have been sent to Colorado, and told by their physicians to exercise all that they possibly could, and to do considerable horseback riding. Usually, such cases as follow this advice break down rapidly, either from spreading of lung trouble, or from the occurrence of hæmoptysis. Cases, as a rule, will not find an immediate amelioration of their symptoms on going to Colorado, but, on the contrary, cough and expectoration are frequently increased the first few weeks or months. When I went to Colorado I was firmly impressed with the idea that if I ascended the altitude rapidly I should probably bring on a pulmonary hemorrhage. I spent about a week travelling about from town to town in Kansas, until I had reached an altitude of about two thousand five hundred feet, when I determined to go to Colorado Springs at once. When I arrived there, I went immediately to bed, and was unable to tell, from my sensations, pulse, temperature, or respirations, that I was so far above sea-level. I learned

from the physicians there that a hemorrhage is the exception in persons just reaching Colorado, especially if they keep quiet. I now believe that if the proper precaution is taken there is no necessity for invalids to ascend the mountains gradually. There certainly would have to be an urgent need to induce me to attempt it again. The great drawback is, that there are but few places after beginning the ascent of the Rocky Mountains where you can be tolerably comfortable before reaching Denver or Colorado Springs. The best time of the year for an invalid to go to Colorado is September. The rainy season is about over, and that portion of the year which is so delightful is just beginning. Patients improve most during the fall and winter months. If they do not lose some during the spring months they are fortunate. Those that are cured by Colorado climate are few in comparison with the many that are benefited and enabled to live comfortably for many years. A small number are able to return East and live, but those who thus venture to do so and break down the second time, receive much less benefit on again going to Colorado. It should be a rule, from which there ought to be as few exceptions as possible, that when a consumptive patient finds a climate that agrees with him, he should there make his home for the remainder of his life.

In conclusion, let me say something of the advantages and disadvantages of Colorado Springs. It has nearly six thousand inhabitants, numerous churches and schools, good hotels, and a number of first-class boarding-houses. There are two parks, and the streets and avenues are wide and shady. The water which supplies the city is the melted snow from the Pike's Peak region, and is as nearly pure as possible, and delightfully cool. It is conveyed several miles through an iron pipe which taps the stream in the mountains above the point of possible contamination from human excrementa. A large proportion of the inhabitants are intelligent, professional, and business men who have been unable to live East. It is very doubtful whether one could find another place the size of it, in this country, where so much intelligence, ease, and comfort exist. A great many there live off the income of capital invested in other sections of the country. It is, in many respects, like a watering-place, and, in consequence, is far from being a brisk, lively, business town. It is possible to get nearly all

the comforts there that can be obtained in a large city. The disadvantages are very great for those poor invalids who go there hoping to earn their expenses. It costs considerable to live there and fare as well as consumptive invalids should. Table board at the best boarding-houses is eight dollars per week. Board and room vary from ten to fifteen dollars per week. It is very difficult for many to get any thing to do to aid them in meeting their expenses. These facts should be known by consumptive persons in moderate or needy circumstances, before they make the journey of nearly two thousand miles to regain their health in Colorado Springs.

I have endeavored to make my remarks as practical as possible. I trust that I have succeeded without trying your patience.

THERAPEUTIC NOTES.

ANTHRAX.

R. Acidi carbolici . . . gr. ij.
Chloral hydrat. . . 3j.
Elixir curacoa . . . ʒiiss.

M. Sig.—Teaspoonful every four hours.

BLACK MEASLES.

R. Tinct. belladonna . . . 3ss.
Tinct. capsici . . . 3j.
Tinct. benzoini comp. . . ʒij.

M. Sig.—Teaspoonful every two hours.

FISSURE ANI.

R. Ext. belladonna . . . gr. x.
Bismuthi subnitratis . . . ʒiij.
Acidi carbolici . . . gr. v.
Adipis . . . ʒiiss.

Sig.—Apply three times daily.

ERYSIPELAS.

R. Antimonii et potassii tart. . gr. ij.
Potassii nitratis . . . ʒiij.
Aqua . . . ʒij.

M. Sig.—Teaspoonful in water every three hours.

RICKETS.

R. Tinct. belladonna . . . ʒvj.
Tinct. nux vomica . . . 3j.
Syr. calcii lactophosphatis . ʒiij.

Sig.—Teaspoonful after meals.

PYROSIS.

R. Acidi carbolici . . . gr. x.
Spts. frumenti . . . ʒj.
Syr. auranti cort. . . ʒiiss.

M. Sig.—Teaspoonful half hour before meals.

CHAPPED HANDS.

R. Plumbi nitratis . . . gr. xv.
Glycerini . . . ʒj.

M. Sig.—Apply freely three times a day.

WHOOPIING-COUGH.

R. Tinct. lobelia . . . 3ij.
Tinct. opii . . . 3ss.
Syr. Scillæ comp. . . ʒss.
Syr. tolu . . . ʒiiss.

M. Sig.—Teaspoonful every four hours.

ANÆMIA.

R. Liq. potassii arsenitis . . 3ss.
Strychnia sulphatis . . . gr. ʒ.
Potassii chloratis . . . ʒiiss.
Aqua . . . ʒiv.

M. Sig.—Two teaspoonfuls after meals.

DYSENTERY.

R. Tinct. opii deod. . . 3j.
Acidi tannici . . . ʒij.
Vini portense . . . ʒiv.

M. Sig.—Dessertspoonful every three hours.

CROUP.

R. Tinct. aconiti-rad. . . 3ss.
Tinct. lobelia . . . ʒiiss.
Syr. zingiberi . . . ʒij.

M. Sig.—Teaspoonful every two hours.

HYSTERO-MANIA.

Dr. A. L. Hodgdon (Maryland Medical Journal), says: The following formula I have found useful as a calmative in hystero-mania (hysterical insanity):—

R. Ext. cicicifig. . . ʒʒiiss.
Ext. vibur. prunifol. . . ʒʒj.
Ext. conii . . . ʒʒj.
Tinct. cannab. indic. . . ʒiiss.
Syrup . . . 3x.

M. Sig.—Two teaspoonfuls three times a day, and see that its components are thoroughly mixed before exhibiting:

Two of the ingredients of the formula before mentioned—the hemp and the hemlock—are of notoriously uncertain strength. Hence the proportion of each of these drugs to the rest of the prescription must always be governed by their respective strengths, and the mixture should never be administered excepting with extreme caution, carefully watching its effects.

INFANTILE COLIC.

R. Spts. chloroformi . . . 3ss.
Syr. simp. . . ʒiiss.
Aq. menth. pip. . . ʒiiss.

M. Sig.—Teaspoonful when necessary.

TARTAR EMETIC IN LABOR.

Dr. Caleb Green (Philadelphia Medical Times) says tartar emetic is one of our most efficient agents in promoting parturition. When the pulse is tense, the os rigid, the skin dry and hot, the advance of the head slow, I have seen, by the use of small doses of antimony, the most prompt and happy change for the better. The pulse softens, the skin becomes moist, the rigid os relaxes, the vagina becomes bathed in a plentiful supply of mucus, and the uterine contractions hasten on to a speedy termination of the labor.

It is not a substitute for ergot, but it has properties which make it much oftener available as a means of hastening labor to a happy termination. If the dose can be so graduated as to produce its effect as a parturient just short of nausea, and especially short of vomiting, the effect seems to be better than where vomiting occurs.

NERVOUS EXHAUSTION.

R. Tinct. ignatia 3iss.
Pulv. myristica 3ij.
Ext. erythroxyli f3ij.

Sig.—Teaspoonful after meals and at bedtime.

PALPITATION OF THE HEART.

R. Tinct. veratri viridi 3ss.
Tinct. belladonna mvi.
Tinct. lobelia 3ss.
Elix. simp. 3iiss.

M. Sig.—Teaspoonful three times a day.

FLATULENT COLIC.

R. Ol. myristica 3ss.
Spts. chloroformi 3j.
Spts. frumenti 3iss.

M. Sig.—Teaspoonful every half hour.

PHARYNGITIS.

R. Tinct. aconiti rad. mxx.
Tinct. myrrhæ 3ij.
Tinct. guaiaci ammoniat. 3iss.
Syr. zingiberi 3ij.

M. Sig.—Dessertspoonful every three hours.

IRRITABLE BLADDER.

R. Tinct. gelsemii 3ss.
Potassii bromidi 3vj.
Aqua 3ij.

M. Sig.—Two teaspoonfuls every two hours.

PERITONITIS.

R. Tinct. aconiti rad. 3ss.
Morphia sulphatis gr. ij.
Syr. auranti cort. 3ij.

M. Sig.—Teaspoonful every two hours.

INTERMITTENT FEVER.

R. Tinct. veratri viridi mxxiv.
Quinia sulphatis 3j.
Syr. yerba santa 3iss.
Elix. simp. 3iiss.

M. Sig.—Two teaspoonfuls every three hours.

HÆMOPTYSIS.

R. Tinct. veratri viridi mxxv.
Tinct. matico 3j.
Vini portense 3ij.

M. Sig.—Tablespoonful every hour.

NEURALGIA.

R. Tinct. aconiti rad. 3ss.
Ol. menth. pip. 3ss.
Spts. chloroformi 3j.

M. Sig.—Apply externally.

DYSMENORRŒA.

R. Ext. cimicifuga f3iss.
Vini colchici rad. 3ij.
Elix. simp. 3j.

M. Sig.—Teaspoonful every three hours.

ASTHMA.

R. Potassii iodidi. 3iss.
Tinct. lobelia 3ij.
Aqua 3iiss.

M. Sig.—Teaspoonful every two hours.

URTICARIA.

R. Antimonii et potassii tart. gr. ss.
Magnesii sulphatis 3ss.
Aqua 3iv.

M. Sig.—Two teaspoonfuls every two hours.

GASTRALGIA.

R. Tinct. opii 3j.
Tinct. hyoscyami 3ss.
Aqua lauro-cerasi 3ij.

M. Sig.—Teaspoonful every four hours.

GOUTY BRONCHITIS.

R. Potassii bicarb. 3ss.
Vini colchici rad. 3ij.
Mist. glycyrrhizha. comp. 3ij.

M. Sig.—Teaspoonful in water every three hours.

JAUNDICE.

R. Aloini gr. j.
Vini colchici rad. 3iss.
Ext. taraxici f3ij.

M. Sig.—Teaspoonful every four hours.

LARYNGISMUS STRIDULUS.

R. Morphia sulphatis gr. ss.
Chloral hydrat. 3j.
Syr. simp. 3ij.

M. Sig.—Teaspoonful every hour.

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CAPSICUM.

CAPSICUM though somewhat neglected is one of the most important remedies in the materia medica. It has no superior as a safe and effective general stimulant. It increases the secretion of the salivary glands, promotes the formation of gastric juice, and increases the secretion of the intestinal glandular system. It accelerates the heart's action, increases arterial tension, and produces a feeling of warmth and well-being throughout the entire system. It increases the urinary and cutaneous secretions, and acts as a stimulant to the organs of reproduction. It is invaluable in the treatment of atonic dyspepsia, and in the apepsia of chronic alcoholism. It is the most efficient agent that can be used to overcome the craving for alcohol in dipsomania. It is also useful in the treatment of the opium habit. Incipient delirium tremens may be prevented, and a pronounced attack aborted, by the administration every hour of half-drachm doses of the tincture of capsicum, or from twenty to forty grains of the powder. Gastralgia, enteralgia, and flatulent colic may be readily relieved by a few five-minim doses of the tincture. Capsicum is effective in the treatment of flatulent dyspepsia, hysterical flatulence, and the tympanites of typhoid fever. It is also valuable in the latter disease, and in typhus and other low forms of fever as a general nervous and cardiac stimulant. It is one of the most potent remedies that we possess for cholera morbus, cholera infantum, and Asiatic cholera. Diarrhoea and dysentery, especially when due to the presence of fermentative material in the alimentary canal, may be quickly checked by large doses of capsicum. It will also be found of benefit in chronic malaria. It is more effective than any other remedy in the treatment of

the asthenic types of scarlet fever, diphtheria, smallpox, and other zymotic diseases. In phthisis, leucæmia, anæmia, and chlorosis, it stimulates the appetite, promotes digestion, and increases the activity of the blood-producing organs. It is also valuable in the treatment of amenorrhœa of thin, pale, or nervous subjects. In these cases the tincture should be given in five-minim doses three times a day for a week before the time at which the menses are expected to appear.

Capsicum is invaluable in the treatment of functional impotence, and the impotence of nervous subjects. It is also of service in spermatorrhœa, prostaticorrhœa, leucorrhœa, and chronic cystitis. It may be added with advantage to the various expectorant mixtures employed in chronic bronchitis. It is also serviceable in chronic constipation, and in the treatment of hæmorrhoids when due to a relaxed condition of the rectal mucous membrane. A gargle composed of one drachm of the tincture of capsicum, two drachms of salt, and half a pint of water, will be found beneficial in chronic pharyngitis, relaxation of the uvula, and in hoarseness due to a relaxed condition of the vocal chords.

External applications of capsicum are valuable in the treatment of hysterical paralysis, lumbago, chronic rheumatism, torticollis, neuralgia, and stomachic and intestinal colic. The tincture is an excellent application to indolent ulcers and unbroken chilblains.

THE TREATMENT OF SCARLET FEVER.

THE first aim in the management of scarlet fever cases should be to prevent the further spread of the disease. The patient should be placed at once in a large, well-ventilated room, from which all carpets and unnecessary articles of clothing and furniture have been removed, and from which all persons must be excluded except the physician and nurse. As the contagion resides in the secretions of the patient, as well as in the scales which are cast off during the process of desquamation, the urine and sputum, as well as the discharges from the bowels, should be sprinkled with sulphate of iron, or some other

disinfectant before being thrown into the water-closet. All scales should be collected and burned. In addition, the entire surface of the patient's body ought to be thoroughly anointed every day with cocoa butter, cold cream, or cod-liver oil. These oily unctions will be found to be sedative and grateful, as well as effective in preventing the scales from mingling with the atmosphere of the room.

Medicinally, the endeavor should be, first, to lower the temperature of the patient; second, to lessen the force and frequency of the cardiac movements; third, to moderate the throat symptoms; fourth, to maintain the nutrition of the patient, and, fifth, to prevent the development of renal and other complications. It is neither advisable nor necessary, however, to prescribe different sets of remedies for each of the symptoms of the disease. The rapid pulse and the pyrexia react upon each other, and combine to aggravate the swollen and painful condition of the pharynx and tonsils. In ordinary cases—in which the pulse varies from 120 to 140, and the temperature ranges from 101° to 103° Fahr.—the most gratifying results can be obtained from the administration every three hours of from twenty drops to a teaspoonful of the following combination, according to the age of the patient:—

R. Tinct. aconiti rad.	3ss.
Potassii chloratis	3j.
Syr. simp.	3ij.

A purgative dose of calomel and soda, or calomel and resin of jalap should also be given in the beginning, and the bowels kept soluble during the course of the disease by the use of saline laxatives.

In the severer grade of cases, in which the temperature rises to 104° or 105° Fahr., and the pulse varies from 130 to 160, the aconite should be increased in quantity and given every hour until a decided impression has been made upon the pulse-rate. An ice-bag should also be kept constantly applied to the head, and a drastic purge, consisting of an ounce of magnesia sulphate, or two drachms of compound jalap powder should be given immediately, and repeated in four hours unless copious intestinal evacuations have occurred in the meantime. The severity of the throat symptoms in this

class of cases can be abated considerably by applying ice-cold cloths to the neck, and by permitting the patient to swallow small pieces of ice.

In the malignant variety of the disease when the temperature frequently reaches 106° or 108° Fahr., the same line of treatment must be carried out but with greater energy. The patient should be stripped, an ice-cap placed upon his head, and affusions of ice-water applied to the entire surface of the chest and abdomen until the fever has receded several degrees. Full doses of aconite should then be administered at frequent intervals until the pulse and temperature reach the safety limit. Free purgation is also indispensable. Tincture of veratrum viride, from a half to five drops, or tincture of pulsatilla, from one to ten drops, may be substituted for aconite if desired, but no benefit need be expected in cases of the asthenic type from the employment of iodine, carbolic acid, opium, or carbonate of ammonia. Stimulants are not only useless but positively injurious. Chloral is occasionally of service in quieting delirium and producing sleep, but it has no value as an antipyretic. In cases in which the tonsils, uvula, and the back of the pharynx are covered with a thick, yellowish, offensive deposit more benefit can be obtained by the occasional administration of an emetic of ipecac, apomorphia, lobelia, or salt and water, than by any form of local applications.

In cases of the asthenic variety, characterized by a weak, tremulous, and rapid pulse, low delirium, and irregular development of the eruption, aconite and veratrum should be discarded, and reliance placed upon belladonna, capsicum, nux vomica, turpentine, and other stimulants to the cerebro-spinal and vaso-motor systems. Carbonate of ammonia and small doses of opium may also be given with advantage in this form of the disease. ●

Diet is of the utmost importance in the treatment of all cases of scarlet fever. The disease is frequently a protracted one in which the vital powers are taxed to the utmost extent. The patient should be given a cup of warm milk, a small quantity of milk-toast, or a cup of beef-broth, well salted and peppered, every four hours; grapes, oranges, and apples, may also be partaken of with benefit.

When the fever declines and desquamation begins, care must be taken to prevent the kidneys from being called on to do more than their share of the work of eliminating the products of disease from the system. This can be done most certainly by keeping the patient warm and the skin active, and administering a sufficient quantity of magnesia sulphate or other saline laxative to secure two or three intestinal evacuations daily until convalescence has been fairly established. The tincture of the chloride of iron, alone or combined with nux vomica, should then be given for several weeks.

When renal engorgement occurs, resulting in dark-colored albuminous urine and more or less anasarca, copious diaphoresis and free purgation should be procured.

CORRESPONDENCE.

OUR PARIS LETTER.

EUDOXIE HELOUIN, the CATALEPTIC OF THE SALPÊTRIÈRE — HYSTERICAL APOPLEXY — DISAPPEARANCE OF HYDROPERITONEUM IN HEPATIC CIRRHOSIS—PUNCTURING THE UTERUS IN ACUTE HYDRAMNOS—PNEUMOTOMIA —PNEUMOTHORAX IN CHILDREN—RECTAL INJECTIONS OF MEDICAL GASES.

Eudoxie Helouin, the patient at the Salpêtrière Hospital who has just woke up after eighteen days' sleep, entered the Salpêtrière Hospital in 1862. Her mother died from cancer of the stomach. During six years she was subject to epileptic attacks, but these occurred after the birth of Eudoxie. This patient cannot give any information concerning her childhood, whether or not she had convulsions, all she remembers is that she cried and laughed without cause. When she was eighteen years of age epileptic attacks came on, under what circumstance is not known. At nineteen she was treated for gastritis; at twenty she miscarried at the fifth month of pregnancy. She was ill during the eight months that followed, and suffered from frequent uterine hemorrhage. During pregnancy she suffered greatly from nausea, but her epileptic fits were not modified. After a series of these attacks, which occurred when Eudoxie was twenty-two years old, she became paralytic, and remains so. Her first entry at the Salpêtrière was for the purpose of being treated for paralysis. Her lower limbs were perfectly rigid; she suffered acute pain in the knee, and the left knee was con-

siderably swollen. She was cupped, the marks of cicatrization are still visible; she then went from hospital to hospital, and in 1865 was attacked by cholera. In 1866 she again entered the Salpêtrière Hospital. She had grown very obese, the abdomen had greatly increased in size; she scarcely ate anything. On the left side of the abdomen there was dulness on percussion; examining the patient produced what, coupled with her obesity, rendered it impossible to ascertain the cause of the symptoms, whether there had been peritonitis or an ovarian cyst. The patient could move her arms freely, but the lower limbs were paralyzed. On the 7th of May, 1875, Eudoxie fell asleep, after taking a purgative. The face was calm, the eyelids frequently quivered, and did not always close and hide the globe of the eye. When her head was shaken she awoke easily, and said she did not dream. On the afternoon of the same day she slept a long time; on the 8th she frequently fell asleep, and was easily awakened; on the 12th her sleep persisted, and continued until the 27th. The following day, the 28th, she made a meal, after it laughed violently, and then became delirious. The next morning, the 29th, her upper and lower limbs were rigid, but not her feet. Last January she slept during fifty days. She has now just awakened from a sleep of eighteen days. During her attack of somnolence Dr. Voisin placed on her skin, without saying anything, an emetic well wrapped up. This did not produce any effect, it was removed, and replaced by a piece of paper, carefully folded and quite empty. On placing it Dr. Voisin said, "You will see the effect of this emetic I have placed on the patient's epidermis; she will certainly vomit." Ten minutes afterward the patient was sick, which proved that during her sleeping fit she could hear. The day after she awoke, she was given an empty glass, which she was told contained champagne, and a piece of aloes as sugar. She made a grimace on eating the piece of aloes, two or three times simulated emptying the glass, and then manifested the symptoms of drunkenness. Since Eudoxie has awoke the last time, she eats, drinks, sleeps, and cuts her nails, but her mental condition is not normal. She is now fifty-one years of age.

Cases of hysterical apoplexy have not yet been described, nevertheless they are by no means of rare occurrence. At a recent meeting of the Société Médicale des Hôpitaux, M. Deboue communicated the following facts. On the 10th of July a healthy man, 31 years of age, suddenly became insensible as he was leaving the dinner table. He remained in a comatose condition for twelve hours. On recovery he presented motor paralysis of the left side. There was an absence of convulsions. The following morning when he appeared at the hospital there was motor

paresis on the left side, accompanied with hemianæsthesia. All the symptoms of the case established the diagnosis of ordinary apoplexy. M. Debove believes it to be hysterical apoplexy. The patient was certainly strong and robust, and not suggestive of hysteria. Nevertheless, on the left side, the skin, mucous membranes, the ear, and muscles were insensible, the pupil was contracted; the patient was unable to detect violet, and presented monocular polyopia. On applying a magnet, anæsthesia shifted from the left side to the right. On repeating the experiment the left side became anæsthetized, and the right side presented its normal sensibility. When there is absence of organic lesion, motor paralysis is generally co-existent with sensory paralysis of the region attacked. Professor Charcot admits two varieties of anæsthesia—one hysterical, another organic—this latter is rarely met with. M. Debove's view is supported by a note by M. Vulpian, which has appeared in a medical paper. The patient referred to in it presented hemianæsthesia, preceded by sudden loss of consciousness; these and other symptoms had led M. Vulpian to localize the cerebral lesion. At the necropsy the two cerebral hemispheres were completely normal. M. Debove, in consideration of the phenomena of restoration, transference, oscillation, and anæsthesia exhibited by this patient affirms that the case is one of nervous apoplexy. Notwithstanding the etiological objections to the word "hysteria," it may be called hysterical apoplexy, as it is a term under which is included a certain class of symptoms similar in kind. Hysterical apoplexy with anæsthesia is not astonishing. M. Debove reminded the meeting, that quite recently in some cases of anæsthesia from intoxication, either alcoholic, mercurial, or from lead poisoning, the anæsthetic condition was connected with hysteria; the anæsthesia was rather symptomatic anæsthesia, than toxic anæsthesia.

M. Dujardin-Beaumetz has noted in his wards a very interesting case. A patient, 38 years of age, was suffering from cirrhosis, accompanied with considerable ascites when he entered the Cochin Hospital. Five litres of fluid were removed by means of a puncture. The diagnosis made was atrophic cirrhosis. The cachectic condition gradually disappeared, the patient became stronger, and the general condition improved. Ascites did not reappear; the patient appeared cured and was allowed to leave the hospital. He immediately resumed his habit of getting drunk, was found insensible on one of the boulevards, and was removed to the hospital where he died of pneumonia. The necropsy revealed the presence of pulmonary lesions and hepatic cirrhosis. Microscopic examination confirmed the accuracy of a microscopic examination.

M. Dujardin-Beaumetz in treating the case remembered that cirrhosis is most often cured after a crisis—after exaggerated diarrhoea, for instance—and that Dr. Pouletfele Plancherclès Mines has recently prescribed hippurate of lime for hepatic cirrhosis, he therefore administered to his patient a syrup composed as follows: Hippuric acid, 25 grammes; milk of lime (*lait de chaux*) sufficient to neutralize lime water; 500 grammes syrup of sugar; 600 grammes spiritus citrus. This was given in doses which insured from four to eight grammes of hippurate of lime being taken daily. M. Beaumetz cannot assert that this mixture has any curative power, but it is perfectly harmless, and may be generally tested. Doctors do not agree as to the time when the tapping ought to be effected. When hydroperitoneum accompanies cirrhosis, some say as soon as a certain quantity of fluid is accumulated; others advise it only when there is compression and asphyxia is threatened. M. Dujardin-Beaumetz believes that a puncture ought to be made as soon as ascites reaches a certain development. At a recent meeting of the Société Médicale des Hôpitaux, M. Troisier showed a patient he believes to have hepatic cirrhosis; ascites after being abundant disappeared. At the time he entered the hospital there was considerable oedema of the lower limbs and acute ascites. The subcutaneous abdominal veins were much swollen, and the patient owned to drinking on an average three litres of wine a day, nevertheless he did not present any symptoms of alcoholism. A few days after his entry at the hospital ascites increased and pushed upwards the diaphragm; the fluid present was estimated to represent four litres. The patient was put on milk diet; the urine passed rose from five hundred grammes to five litres and a half. Eight days later on the abdomen regained its normal volume, and ascites have not reappeared. The liver and spleen are slightly hypertrophied, the complexion is yellowish and the patient is thin, he nevertheless appears to be getting cured of cirrhosis.

M. Tillaut's wards are always fruitful in clinical teaching; at the present moment a most interesting case can be studied there. A woman, 37 years of age, apparently of a healthy temperament, was sent to the hospital by two doctors in private practice. Her abdomen had assumed such proportions that she could scarcely breathe; she stated that she believed she was pregnant; it was five months since she had menstruated; she had had five children, two of these were twins which lived only twenty days; delivery was always easy without any complication or consequent troubles. Since the last delivery she was susceptible to the influence of cold; when the abdomen became cold it became swollen and painful. Its enormous increase in size was

rapidly attained. The diaphragm was pushed upwards and threatened the patient with asphyxia. It was difficult to ascertain whether the tumor was present previous to the disappearance of her menses; the patient's answers to questions made, encouraged the belief that a tumor was present at an earlier period than five or six months before her appearance at the hospital. When M. Tillaut examined the tumor he ascertained that it was full of fluid. A few days after this first examination, on the left side and in front, certain symptoms were observed which were opposed to the hypothesis of a unilocular cyst; the hypothesis of amniotic dropsy was suggested but not admitted. A few days later on the patient was examined and the signs were favorable to the belief in the presence of a unilocular cyst, the surface was equal and the resistance uniform. An operation was necessary, the patient was almost suffocated, could neither eat nor sleep. The patient was tapped, the fluid that escaped was clear, slightly yellow, free from viscosity, which suggested that it was amniotic. M. Tillaut, whilst allowing the fluid to escape, kept his hand on the surface of the tumor and felt it harden and contract similar to uterine contraction when parturition commences. The patient declared she suffered pain similar to labor pains at the onset. This enormous tumor, which contained at least twenty litres of fluid, was a uterus dilated at the fifth month of pregnancy by subacute hydatidosis. M. Tillaut decided that in the interest both of mother and child he ought to diminish the quantity of amniotic fluid, but, nevertheless, ought to leave a sufficient amount that the infant should be surrounded by normal conditions; seven litres were withdrawn, the patient was much relieved, collodion was painted over the orifice left by the trocar, a hypodermic injection of half a centigramme of morphine, and an injection containing laudanum stopped the uterine contractions. The patient continues in a satisfactory state, the fetus moves; the mother declares it to be very vigorous.

At a recent meeting of the Paris Surgical Society, M. Reclus described a case which showed that the diagnosis of pulmonary hydatid is sometimes excessively difficult. A hydatid cyst of the chest was diagnosed in a young girl by means of making an exploratory puncture, the contents of the cyst were vomited by the patient, and it was believed that she had a pulmonary cyst. In order to open the sac more completely, M. Reclus performed resection of the twelfth rib; this operation showed that the patient was suffering from hepatic cyst and was subsequently cured.

M. Moutard Martin, it was stated by M. Bouilly, had performed thoracentesis on a patient who it was believed presented empyema, and he discovered that a hepatic hydatid tumor had opened

into the bronchi; the sac was lined with pulmonary tissue.

At a recent meeting of the Société Médicale des Hôpitaux, M. Sevestre read notes of two cases of pneumothorax observed in children of sixteen months old. The author's investigations on this subject demonstrate that this affection occurs much more frequently among children than is supposed, and that the symptoms it exhibits are the same as those presented by adults.

Rectal injections of medical gases as a method of treatment are based on a physiological principle established by Claude Bernard, that the introduction per rectum of toxic substances is not dangerous as long as pulmonary elimination is perfectly normal. Dr. Bergeron has adopted this method of treatment in several affections and publishes the results obtained in pulmonary phthisis. A current of from four to five litres of carbonic acid gas is passed through 250 to 500 grammes of mineral water containing sulphur (Eaux Bounes, Allevard, Saint Honoré, Challes), and then introduced into the rectum. In the course of twenty-four hours two injections are made. After two days had elapsed, this treatment had cured the cough which had troubled the patient, expectoration was modified in quantity and character, the profuse perspiring of phthisical patients was removed, general condition improved not only in phthisis at the onset, but also in confirmed phthisis. Daily auscultation showed that the râles gradually disappeared.

MEDICAL NEWS AND MISCELLANY.

DR. A. H. BECKMAN has removed to 525 Catharine Street.

DR. ADDINELL HEWSON, JR., has removed to 1816 Spruce Street.

DR. A. R. SMART has removed from Hudson, Mich., to Toledo, Ohio.

DR. PETER MCCAHEY has removed to 304 North Eighteenth Street.

DR. WILLIAM DELKER (Class of 1884) was married on September 15th to Miss Laura V. Woodward, of Ellisdale, N. J.

DR. P. R. KOONS, President of the Class of 1879 (Jefferson), is enjoying a large and lucrative practice in Mechanicsburg, Pa.

DRS. WILLIAM H. WARDER and E. E. MONTGOMERY have established a Private Hospital for Women at 1401 North Sixteenth Street, Philadelphia.

DR. S. O. L. POTTER has been elected to the Chair of Theory and Practice of Medicine, in Cooper Medical College, San Francisco, Cal.

THE numerous friends and admirers of Dr. Morris P. Henry will be gratified to learn that he has returned from Europe renewed in health, after a much-needed period of rest from professional cares, and has resumed practice at his residence, 581 Fifth Avenue, New York.

THE AMERICAN ACADEMY OF MEDICINE has elected the following officers: President, Dr. L. P. Bush, Wilmington, Del. Vice-Presidents, Dr. R. Lowry Sibbett, Carlisle, Pa.; Dr. Samuel J. Jones, Chicago; Dr. Phineas T. Connor, Cincinnati; Dr. Virgil P. Gibney, New York. Secretary and Treasurer, Dr. R. J. Dunglison, of Philadelphia.

THE PHILADELPHIA SCHOOL OF ANATOMY.—This flourishing institution, which is now under the guidance of Dr. Henry C. Boenning, Demonstrator of Anatomy in the Medico-Chirurgical College and Philadelphia Dental College, offers unusual facilities to students of medicine and to practitioners desirous of refreshing their anatomical knowledge or pursuing special inquiries.

COCAINE ADDICTION.—If any reader of your journal has met with a case of cocaine addiction and will send me the fullest details at his command, I'll thank him for the courtesy, reimburse him for any expense incurred, and give him full credit in a coming paper.

J. B. MATTISON, M.D.

BROOKLYN, 314 State Street.

PERSONAL JOURNALISM.—Dr. Shrady, editor of the Medical Record, continues his personalities in the pages of that journal. Before he prostitutes its columns to such purpose, he had better look over his own record, and reflect by what discreditable means he forced himself into General Grant's case, the story of which we could tell if we felt like imitating his example.—*Medical and Surgical Reporter*.

NEBRASKA STATE MEDICAL SOCIETY.—At the late annual meeting of this society the following officers for the ensuing year were elected: President, Richard C. Moore, M.D., of Omaha; 1st Vice-President, Milton Lane, M.D., of Lincoln; 2d Vice-President, M. J. Donaldson, M.D., of North Platte; Corresponding Secretary, H. B. Lowrey, M.D., of Lincoln; Recording Secretary, A. S. von Mansfelde, M.D., of Ashland.

GIVE US THE NAME.—The American Practitioner and News says that "a well-known American physician wrote to us from Berlin that he had come in contact with medical men in Bremen, Hamburg, Dresden, Munich, Vienna, and Breslau, and that everywhere he found the profession felt very little inclination to incur the trouble and expense of a trip across under such damaging auspices to attend the Congress," and he adds, "my replies to the questions only corroborated previous impressions." This sounds

so like the reported efforts of Dr. Mundé in this direction, that we would call for the name of the man. Stamp the man who will go out of his way to assail and help break down the profession of his country. Shame on such a man! Give us his name!—*New England Medical Monthly*.

A NEW HYPODERMIC POCKET-CASE.—We have received from Messrs. Burroughs & Wellcome, Snow Hill, London, a new hypodermic pocket case, with a syringe made of solid silver. The pocket-case is much smaller than those usually met with, and has space for from ten to fifteen varieties of hypodermic tabloids in a leather cover of the following dimensions—three and a quarter by two and a half by three-quarters inches. The syringe is made of solid silver throughout, and is, therefore, non-corrodible. It is inclosed in a solid silver case, which protects it, and prevents the drying of the piston packing. It is an instrument which may be relied upon in cases of emergency when other syringes are so likely to be found broken, or with dried up packing or rusty needles. The cap of the case answers admirably for a mortar in which to crush and dissolve the tabloids, while the piston-rod and handle answer for a pestle. The price of the case complete with syringe, and twelve tubes of tabloids, is twenty-five shillings. It is a model of compactness and fitness.—*British Med. Jour.*

AN UNFORTUNATE POSITION.—The old adage that "chickens come home to roost" seems to be realized by the Jefferson Medical College of Philadelphia.

At the time of the reorganization of the Committee of Arrangements of the Ninth International Medical Congress, as directed by the American Medical Association, at its meeting at New Orleans, and after the first meeting of that committee at Chicago, at which time certain changes were made in the distribution of the offices of the Congress so that the whole country would be represented instead of only a small portion, all of the gentlemen who were appointed by the first, or Billings-Hays Committee, belonging to Jefferson Medical College, resigned. After a time they commenced a series of persecutions against any of the faculty or any one of the corps of lecturers who took any part in the new work of reorganizing the Congress as directed by the parent Association.

The outcome of this was, Drs. Pancoast, Shoemaker, and Atkinson were forced to resign. We speak advisedly and authoritatively when we say forced to resign. But the persecution did not cease here, but personal abuse was resorted to, falsehoods concocted and retailed, and personal character was assailed.

At home, where these gentlemen are so well known for their high professional attainments,

executive ability, well-known probity, and high social and professional position, and where the animus which prompted these slanders was well known, they fell flat and did not avail, but imagine our surprise, while abroad, when we found that in order to injure the Congress, and do all they could to interfere with its success, these stories had been retailed over there, by these gentlemen, *ad nauseam*. Now we see that Jefferson Medical College finds itself upon the defensive, with a most unpleasant prospect before it. The indignation of the profession throughout the country, resenting this outrage upon decency and good order, its depleted list of students, and the bad odor which it finds itself in generally, brought out a protest from its Dean, in the shape of a letter to Daniel's Medical Journal of a recent date—a letter which is a humiliating confession of weakness and subterfuge. Surely how low are the mighty fallen, and what an important lesson it conveys! The moral is apparent. Surely the position is most decidedly unfortunate, and we shall look with interest to see how the College will recover its old position.—*New England Medical Monthly*.

THE CAUSATION OF PNEUMONIA.—In Science for August 13, 1886, p. 133, I notice a paragraph relative to results of observations by Dr. Seibert of seven hundred and sixty-eight cases of pneumonia, wherein it appears that pneumonia prevails to its greatest extent "whenever there exists a low or falling temperature, with excessive and increasing humidity, and high winds." This reminds me that readers of Science may be interested to know that facts respecting a very much larger number of cases, and respecting pneumonia in different parts of the United States, in England, and in India—that is to say, in several climates and under different conditions—confirm to some extent the conclusions reached by Dr. Seibert, as mentioned by Science. Such statistics, presented by abstract at the last meeting of the American Climatological Association, demonstrate, I think, that the sickness from pneumonia is absolutely controlled by the temperature of the atmosphere. The higher the temperature, the less the sickness from pneumonia; and the lower the temperature, the more the sickness from pneumonia. This is equivalent to saying that that part of the conclusion of Dr. Seibert which relates to humidity is an error; because the absolute humidity of the atmosphere is, speaking roughly, directly as its temperature, and there is most sickness from pneumonia when, or soon after, the air is driest absolutely; and there is least sickness from pneumonia when, or soon after, the air contains the most vapor of water—that is, when the temperature is highest. The error of many who have written on this subject, and probably the error of Dr. Seibert, consists

partly in calling the "per cent. of saturation of the air" (technically known as "the relative humidity") the humidity of the atmosphere. But the curve for "relative humidity" is not, when inverted, the same as the curve for pneumonia, as you may see by comparing such curves, on the diagrams I prepared, based upon over twenty-seven thousand weekly reports of sickness in Michigan, by observers in different parts of the State, and upon over one hundred and twenty thousand observations of the psychrometer during the same time—namely, the seven years, 1878–1884. Relative humidity seems to have an opposite relation in the warm months to what it has in the cold months. The fact, which I think I have completely demonstrated, is that, in any given place wherever studied, pneumonia is quantitatively proportional to the coldness and dryness of the atmosphere; and, as this is true for every month of the year, it follows that, if there is any pneumonia which is infectious, it is absolutely dependent upon those meteorological conditions for its action upon the human organism.

In the paper to which I have referred I have advanced a theory of the causation of pneumonia consistent with the facts demonstrated; and, briefly outlined, it is as follows: Air expired from the human lungs is nearly saturated with vapor of water at a temperature of about 98° F., and this contains about 18.69 grains of vapor in each cubic foot. The quantity of vapor exhaled is at all times greater than the quantity inhaled; but, when the air is very cold and dry, the quantity exhaled is excessive, as may be seen when we reflect that air at 32° F. can contain in each cubic foot only about two grains of vapor. The fluid which passes out from the blood into the air-cells of the lungs, and which normally keeps them moist, contains some of the salts of the blood; and the chloride of sodium, not being volatile, is mostly left in the air-cells when the vapor passes out with the expired air. When the air inhaled is excessively dry (as it always is when excessively cold), this salt collects in the air-cells of the lungs in considerable proportion. This is proved by my statistics, which show the increase of pneumonia at such times, taken in connection with the fact that chloride of sodium in the lungs is in excess in pneumonia, which was proved in 1851 by Lionel S. Beale, M.D., of London, England. Dr. Beale also verified the observations by Redtenbacher, made in 1850, that during the onward progress of pneumonia the chlorides disappear from the urine, and reappear when convalescence has been established. In the air-cells, the chlorides are irritating when they become concentrated; but the exudation of fibrin, which is the most prominent condition in pneumonia, is probably favored by a fact in osmosis which is not generally well understood

—namely, that albumin, which it is usually considered will not pass by osmosis, will pass through an animal membrane to a solution of chloride of sodium. Thus the causation of pneumonia by the inhalation of cold, dry air seems to be completely worked out. As a cause of deaths, pneumonia is one of the most important diseases. It is hoped that its prevention may now begin.—HENRY B. BAKER, M.D.—*Science*.

DILATATION OF THE COLON.—Dr. J. S. Jewell recently read a valuable paper before the Chicago Medical Society upon "Overfilling and Dilatation of the Colon." During the last eight or ten years he had accumulated a list of over five hundred carefully studied cases, in which the condition named existed, and concerning which he gave his observations. His mode of investigating the cases in which the overfilling existed has been as follows: The patient is stripped so that the abdomen is bare, the abdominal walls being relaxed. Then he takes a plate of soft rubber, at least two inches in length by an inch and a half in breadth and one-quarter inch in thickness, and a heavy steel hammer, quite as heavy as the ordinary surgical bone hammer. With this the abdomen is carefully percussed over the track of the colon, from its origin, tracing it up under the liver, across and down to the sigmoid flexure. Thus percussing over the track of the colon, and carefully locating every mass of feces (even in persons with fleshy abdominal walls), he has been able to get at its course and contents. Out of these five hundred cases, perhaps a hundred have said they were as "regular as clock-work" in having movements from the bowels. But, upon examination in most such cases, the colon was found to have variable quantities of fecal material lying in it. The part of the colon most subject to dilatation is the sigmoid flexure and the descending colon. At the flexure of the colon, deep in the left hypochondriac region, almost as frequent as in any other part of the course of the colon, he had found it dilated and filled with fecal matter. The next most common situation is the transverse colon, last of all the cæcum. In one case where the colon was very largely dilated, during the thirty or forty hours that were devoted to emptying the same (not continuously but at different times), two gallons or more of material were removed. The common way is to find masses of feces lying in lumps here and there, not filling the entire intestine.

In one case a mass was removed from the right extremity of the colon by massage and flooding the colon its entire length with water. The fact that this mass had remained in the colon for more than nine months was ascertained in this way: The patient had taken a dish of dewberries, such as appear in the fall after the ordinary blackberry has passed its season. He was in ill health, and,

growing worse during his visit, returned home. This was in September. Dr. Jewell saw him early in June following. When the mass was removed it was found to be more or less filled with the seeds of the dewberry, and according to his own account he had not taken berries of any kind since the September previous, certainly no dewberries. This mass was about the consistence of soft putty and the size of a large Irish potato.

In most cases investigated the colon was dilated apparently, in some part or other, all the way from two to three times its proper calibre. This class of patients are all liable to become "bilious," and are habitually taking cathartic pills, mineral waters, etc. In nearly every instance Dr. Jewell could trace their "biliousness" to gradual filling up of the colon, and the disturbance produced from this cause in the digestive apparatus higher up. The change in the secretions of the mouth, the bad breath, the unhealthy odor of the skin produced by absorption of fetid substances from the rotting masses in the intestine, together with the coloring matter in the same, gives the skin of the patient a peculiar dirty, sallow color. One of the first things to occur, in addition to the dilatation and weakening of the muscular coat of the colon by accumulation of material in it, is irritation of portions of the mucous membranes where the fecal masses lie, producing local catarrhs. This occurs with a frequency and to an extent that no one would suspect, unless they set the patient or nurse to carefully watching the stool. The next important factor in these cases is irritation of the peripheral ends of the sensory nerves of the intestinal mucous membrane, irritated by contact with the fecal masses. The nerves that return from the colon probably enter the spinal cord at a level not lower than that of the tenth or eleventh dorsal vertebra. Above the level named they probably enter the cord at various points higher up in the lower two-thirds of the dorsal cord, not to mention direct medulla connections, etc. Along these nerves are propagated the irritative impressions from the colon into the spinal cord or medulla, and thereby "switch" connections, outgoing or reflex impulses are sent to other portions of the body, producing thus various forms of disorder to be referred to later. He believes that he has not found one case out of twenty of ordinary melancholia that has not had its origin partly, or in some cases apparently entirely, in overfilling of the colon. Headache, and a great many transient disorders referred to the head, more frequently owe their origin to this source than he had ever supposed, next to the influence upon the circulation in general, especially upon the heart's action, by lowering its tension and thus giving a feeble pulse.

Dilatation of the colon often causes a sluggish capillary circulation, and this accounts for the frequency with which patients complain of cold extremities. Dr. Jewell has found patients who could not remember having had naturally warm feet for years, when upon removal of the masses in the colon the feet would become warm. In insomnia he has found the condition of the colon described to be a frequent cause, the colon being the seat of the original disorder. There is lowering of the vascular tension nearly always in these cases, hence the feeble nutrition and feeble circulation in the brain, not to mention other parts. The next most important result of dilatation and overfilling of the colon is the fact that these masses of retained fecal substance in various ways poison the individual by absorption of septic material. He has had three cases of epilepsy that he traced exclusively, as far as could be told by the results of treatment afterward, to disease in the left extremity of the colon caused by fecal accumulations, and when the disorder was removed by proper means he was able to remove the epilepsy.

For the removal of these masses, as a rule, he does not use purgatives, but injections are given after the following plan: A large bag fountain syringe, holding half a gallon, is adjusted at a convenient height from the floor, the patient lying down in a knee-chest position. The fluid should flow with considerable force until it makes its way past the upper sphincter, which is at the lower part of the sigmoid flexure; pass one quart to one-half gallon of water, according to the size of the colon, so as to fill the entire organ to the cæcum. In some instances he has been able to introduce as much as a gallon of water into the colon, the patient feeling no serious inconvenience from it; and a half a gallon is a common amount to introduce. The patient is then directed to lie down upon the left side, and by proper massage over the ascending colon the liquid is moved, and with it the contents of the bowel, toward the rectum. This should be done once or twice in the twenty-four hours until the colon is clear, and by this means it should be kept so. After this has been accomplished, give the patient something that will act as a stimulant to the nervo-muscular coat of the colon. A good prescription for this purpose he has found should contain, in pill or capsule form, extract of cascara, a little belladonna, strychnia, hydrastis canadensis, and aloes. By care the colon can be kept clear, and the disorders of the stomach usually disappear, the secretions of the mouth are improved, the skin becomes of a healthier color and loses the distinctly fecal odor that it frequently has.

He has met with a number of cases of so-called typho-malarial fever in their earliest stages with a temperature as high at times as 103° to 105° Fahr.,

in which, by removing a great mass of material undergoing rapid fermentative decomposition at the high heat of the body, leading to rapid distension of the colon with gas, the signs of disease abated in a few hours and rapid recovery occurred. Where there is considerable inflammation in the bowel itself, he introduces water pretty well charged with listerine or some other antiseptic, and a little glycerine or other medicinal agent, and in this way the intestine is purified and cleansed, and the individual immediately improved. It seems now astonishing that it never occurred to him earlier, that to have a mass of feces undergoing fermentation and decomposition in the interior of the body and in contact with an absorbent surface like the colon mucous membrane, is or may be often the real cause of serious diseases.—*American Practitioner*.

BANDAGE AND REST.—Flavel B. Tiffany, M.D., Kansas City, Mo., calls attention briefly to bandage and rest as a therapeutical agent in the treatment of affections of the eye.

In general surgery, bandage and rest is the *sine qua non*. To it, and to antiseptics, the surgeon gives largely his attention.

By the ophthalmologist, bandage and rest has not received the attention that its virtue merits. It is not my purpose to enter into a lengthy discussion of this subject. I merely wish to call the attention of the society to the new method of bandaging the eye after capital operations such as the extraction and needling of cataract, iridectomy, sclerotomy, tenotomy, and strabotomy, or any operation on the eye where it is desirable to support the cornea, keep the eyes at rest, and exclude light and all irritating substances from an impaired orb.

I also wish to call your attention to the most excellent results obtained from this therapeutical agent (bandage) in the treatment of ulcerations of the cornea in keratitis, especially marginal and phlyctenular, as well as in pannus and other affections, in which it is desirable to keep the globe at rest, to prevent irritation from the movement of the lids against an inflamed cornea, to protect from light, dust, and other irritants.

In the last meeting of the Ophthalmological Section of the American Medical Association this subject was discussed. The isinglass plaster was spoken of by Dr. Michel, of St. Louis. In the June number of the American Journal of Ophthalmology appeared an article on the subject of bandaging the eye after cataract operations, by Dr. J. J. Chisholm, of Baltimore, in which he sets forth many of its virtues. In the last number of the Archives of Ophthalmology, Dr. Michel, of St. Louis, came out with quite a lengthy article on the subject, claiming priority in its use; stating that he has employed it to the exclusion of the compress bandage for eleven or

twelve years, with most excellent results. But neither of these gentlemen speak of it as a therapeutical agent in other affections of the eye. Dr. Chisholm heads his article thus: "The Rational Method of Treating Cataract Patients to the Exclusion of Compresses, Bandages, and Dark Rooms." After the extraction of the cataract, he says "the eye is kept closed by a piece of diaphanous isinglass plaster two and a half inches long by one and a half inches wide. The piece of plaster, rendered pliant by soaking in water, is spread on the closed lids, from brow to cheek, and carefully adjusted by stroking it with the keratome (rubber spoon). The plaster soon becomes dry, and the patient is ready to walk from the operating table to his bed in the fourth story of the hospital." Dr. Michel takes exception to the size of the plaster, as above given, thinks narrow strips are better, giving his reasons, which to my mind are not valid. I have repeatedly used the same sized bandage that Dr. Chisholm speaks of, and in the same way, often operating for cataract, and I am well pleased with it. It is even more than he claims. It is light, and, adhering as it does closely to the lids and cheek, it insures a continued muscular tone, keeping the free edges of the lids in juxtaposition. "It does not trammel any other part of the body, and no movement on the part of the patient can possibly disturb it." Dr. Chisholm is of the opinion that before the year is out, it will be universally employed, to the exclusion of the old way of bandaging the eye and committing patient and attendant to a dark room. With it there is no longer the dread of darkness to the patient, nor of the gloomy room to the attendant. The patient can move about in bed *ad libitum*, without fear of bandage dragging upon the eye or getting out of place; neither is there any danger of its being either too tight or too loose, no danger of the patient's exposing the eye to light, or straining it by his great eagerness to test his sight.

Gentlemen, I consider it a perfect eye-dressing; it is light, cool, and safe; and with my experience with it I am sure I shall never return to the old *régime*. I am using the same bandage as a therapeutical agent in treating diseases of the cornea and conjunctiva, especially in ulceration of the cornea, phlyctenular keratitis, and in marginal keratitis.

In conjunctivitis even, it is an admirable adjunct to other treatment. With it, I am confident that ordinary catarrhal ophthalmia, and iritis even, can be much shortened in their course, keeping the eye, as it does, closed and at rest. It is aseptic, and serves as a splint to the organ that requires rest and protection. It is transparent, discloses the condition of the lids, and allows the ophthalmologist to judge of the state of affairs of the deeper structures of the eye from

day to day, or hour to hour, if necessary, without removing the dressing.—*St. Louis Courier of Medicine.*

THE APPLICATION OF INTRA-UTERINE PRESSURE BY THE TAMPON IN DISEASES OF THE ENDOMETRIUM.—Becoming convinced more than ten years ago of the damaging sequelæ of caustics to the uterine cavity, it has been my constant study to cure the diseases of that structure without them. It was in this line of study that I was led to the "application of pressure in diseases of the uterus, ovaries, and peri-uterine structures," as published in the Transactions of the Medical Association of Georgia, in April, 1878.

At the late meeting of the Medical Association of Georgia, I read a paper upon the "Application of Pressure by the Tampon to the Cavity of the Uterus for Diseases of the Endometrium." Since this publication there appeared in the Atlanta Medical and Surgical Journal a translation from the French, by Dr. V. O. Hardon, of this city, upon "Vulliet's New Method of Dilating the Uterine Cavity." It does not seem to have occurred to Vulliet that his method of dilatation was a valuable therapeutic resource. Indeed, the pressure used for dilatation so rapidly modifies the diseased structure it is designed to diagnose that its value as a means of diagnosis is greatly impaired. The more rapid methods of dilatation are far better than by the slow process of the tampon. By the time the dilatation is sufficient for visual exploration, the endometritis, mucous fungosities, polypoid growths, etc., that may have existed will often have disappeared entirely. As a means of dilatation of the uterine cavity the tampon is valuable, but, as a means of diagnosis, it is well-nigh valueless, except in fibroid growths, which from their density would be less affected by the pressure. In such cases as this the touch is far more reliable than the eye, and a tent that would dilate rapidly and admit the finger would afford far better opportunity to make a correct diagnosis.

As a therapeutic measure, the intra-uterine tampon is simple, safe, and marvelous. Chronic inflammation, granular erosions, mucous fungosities, together with the usual subinvolution, rapidly disappear under the influence of the pressure. With the proper observance of the contraindications to all intra-uterine applications, the remedy is perfectly safe. It should, of course, never be used when there is a vestige of inflammation in the peri-uterine structures. I have now a patient at my private infirmary whose uterus has been packed from the fundus to the end of the cervix for more than a month, who rarely goes to bed, except by my instructions, for some hours immediately following the application. So long as there is sufficient oozing of

blood to saturate the tampon, it is removed and reapplied daily; otherwise it remains for two days. If iodoform is used with the packing, as should always be done, the patient is secure against sepsis, the dressing removed being clean and free from odor, though it remain for days. I not unfrequently leave it alone for three days.

The patient is placed in the knee-chest position, or Sims's semi-prone, and the perineum retracted with a Sims speculum, or with any perineal retractor. I use my own speculum, as it separates the vulva and vaginal orifice better, and gives a more satisfactory command of the parts. The anterior lip of the cervix is seized with a tenaculum, and the uterus lifted forward toward the vaginal outlet. A little pledget or roll of cotton, with a thread wound about it, is now seized with the dressing forceps (with small blades) and carried in the uterus quite to the fundus; this being done the blades are sufficiently separated to loosen their hold and partially removed, and the cotton roll caught in a new place and carried up, as was the first, the manoeuvre being repeated again and again until the little roll is thoroughly packed away in the uterus. These little cotton rolls are repeated one on another until the entire cavity is filled. Each piece of cotton is wound about with strong spool thread with a long end left to better facilitate and insure removal. The size and length of the cotton roll should correspond with the size and depth of the cavity to be filled. I have packed as much as one and three-quarter yards of lampwick in a single piece in the cavity of the body. The cavity in this case was unusually large and filled with granulations. I tried the lampwick because of its convenience, but discarded it on account of its hardness and want of elasticity. Nothing does so well as new, clean cotton. The new cotton does not need washing or other preparation. Absorbent cotton does not do so well—it packs too hard and is inelastic. I usually get clean sample cotton from the cotton factors. In this way we can feel sure of using an article that has never been in use.*

The following cases, treated conjointly by my associate, Dr. Noble, and myself, are selected because of their usually intractable nature, and the slow and unsatisfactory results of the ordinary methods of treatment. Dr. Noble has been kind enough to write out these cases for me, and I

give them just as prepared, vouching for their accuracy in every detail. It will be seen that the first case dates back more than two years ago. Since this time Dr. Noble and myself have treated many cases by this method, and I give it now to the profession for the first time in detail, with the assurance of its safety and inestimable value.

In 1871, and while living at Columbus, Ga., I published a paper upon "Uterine Cloth-Tents in Diseases of the Body and Cavity of the Uterus." In that paper the following language is used: "For some years previous to the adoption of the cloth tent I had used strips of cloth or linen saturated with Churchill's tincture of iodine, solution of carbolic acid, or other substances to be used. One end of the strip, folded over the point of a small probe, was passed to the fundus of the uterus; the probe being withdrawn, was again and again introduced, carrying with it at each time an additional fold of the cloth until the cavity was completely packed. This packing was permitted to remain until expelled by the contractions of the uterus, which required usually from six to twelve hours. The firmer the packing the more active the contractions and the quicker its expulsion. It was to avoid unnecessary contractile action, and to make the strips self-retaining, that led to the idea of rolling the cloth or linen strip into a tent, and thus the better to control, by its size and length, the contractions of the uterus, and to secure its retention for any desirable length of time."

Thus it will be seen that several years before the publication of this paper, in 1871, I was in the habit of packing the uterine cavity. I did not then know the value of the pressure I had secured by the intra-uterine tampon, the object then being the thorough medication it afforded. Thus, for the time being, slipped from my hands a remedy of marvelous power.

It will be observed that the intra-uterine packings were usually expelled by the contractions of the uterus induced by its pressure. I have since learned that this occurred then, as it does now, in a certain class of cases, where there is simply mucous inflammation, with more or less sensitiveness. Where there is a large patulous cavity none occurs, nor does it occur in any case if the uterine cavity is slowly and gradually encroached upon and tolerance induced.

Case I.—This case is reported because it was the first upon which we used the intra-uterine tampon. The patient was large, obese, and anæmic—almost completely exsanguinated. Her health had been good up to her last confinement, two years prior to the commencement of her treatment.* In that labor the cervix sustained a laceration on either side to the vaginal junction.

She had the usual train of symptoms dependent

* In the beginning of the treatment in ordinary endometritis the tampon should not be carried further than just within the internal os—the cavity being gradually and carefully encroached upon until the fundus is reached. When the uterus is filled with fungus granulations the tampon should be carried at once to the fundus. The intra-uterine tampon should always be accompanied by a small, but firm vaginal tampon—using glycerine and iodoform on the first pledgets. The patient should be kept in bed for some hours following the treatment, or if there be pain, as long as this continues. If pain is persistent the tampon should be removed.

* Treatment began in February, 1884.

upon such a lesion and upon sub-involution. Six months after labor she began to have hemorrhage from the uterus, which continued almost constantly for eighteen months. There was vesical tenesmus. The bowels were constipated, digestion greatly impaired, and strength gone. She was confined to her bed from sheer exhaustion.

The perineum was partially lacerated. The uterus was about the size of a three months' pregnancy and prolapsed to the floor of the pelvis. There was great eversion of both the anterior and posterior lips, with granular degeneration or fungosities of the endometrium. The cervical canal and internal os were quite patulous, which permitted thorough exploration. A slight touch was sufficient to produce a hemorrhage, serious to a person in her condition.

The treatment consisted in the proper regulation of diet, nourishing food, tonics, etc., with daily iodoform and glycerine dressings in the vagina, of sufficient firmness to control hemorrhage.

In four days she recovered strength enough to sit in an easy chair the greater part of the day, and at the end of a week walked from the house to the street. Seven days later she walked one-third of a mile. At this time, the end of the second week, the bleeding was so free when the tampon was removed from the vagina that it was useless to attempt to keep it sponged away. It was, therefore, decided to pack the cavity to stop it*. This we did daily, as described by Dr. Taliaferro himself.

The improvement was marked as it progressed by a gradual decrease in the bleeding at each treatment, and in a few days by the appearance of pus, which gradually increased as the packing went on. Immediately following the removal of the first few dressings there was very free bleeding, but this was of no moment, as it was quickly checked by the fresh packing.

We continued this treatment for eight weeks, at the end of which time there was not even a stain of blood upon the cotton as it came away. We subsequently found to our astonishment that we came near producing atrophy of the uterus, as that organ was just a little under the normal size for a multipara.

Case II.—I report this case because of its most unfavorable condition for such treatment. In fact it was contra-indicated. The patient was a small Irish woman with a history of good health up to two years prior to the time I first saw her. Her trouble began with a miscarriage, complicated with bilateral laceration of the cervix and post-

partum hemorrhage. She said the placenta was removed by the hand. The usual train of symptoms accompanying this laceration and sub-involution followed with occasionally an attack of peri-uterine inflammation. She had metrorrhagia for two months before I saw her, for which she was treated by another physician with tents. This resulted in peri-uterine inflammation and a very great increase of the bleeding. Tamponing the vagina was required to check it.

Though active inflammation had been going on, she bled until she was reduced to a sub-normal temperature when I first saw her. At the end of two weeks the inflammation had subsided, and an exploration of the pelvic organs was made. The uterus was nearly as large as an infant's head, almost filling the pelvic cavity. Some inflammatory deposits were in the broad ligaments, yet the womb was slightly movable. The cervical portion of the os was three inches in diameter, and very greatly congested. A slight brush would remove the epithelium and set up a profuse oozing of blood from the cervico-vaginal mucous membrane. The os and cavity were granular. The cervical canal and internal os were very much dilated. The lips were very much enlarged. The anterior lip was about the size of a black walnut, and felt like a fibroid induration. During my absence from the State she had a recurrence of her menorrhagia, and I returned in time to check it just as it had increased to a hemorrhage that bled her almost to syncope while lying in bed. Her circulation was in a very feeble condition from the loss of blood.

I began the uterine packing at once, as she had no more blood to spare, guarding it with a vaginal tampon. Each treatment was followed by a decrease of blood and a corresponding improvement in strength. At first the uterine cavity seemed to dilate until I could pack three little soft twists of absorbent cotton about half the size of a lead pencil and about fourteen inches long into it. Then it began to give her pain—a bearing-down pain—for about two hours after its introduction. As the improvement went on the uterus contracted more firmly until finally it threw the whole dressing into the vagina. The blood had ceased to stain the dressing for three weeks, and as other evidences of disease had disappeared, I decided to leave the treatment off for a few days that I might determine the size of the uterus. This I found was normal, and as she refused an operation on the cervix, the case was dismissed, at the end of the fifth week, cured—all but the cervical rupture.

This case is interesting from the fact that such a large sub-involved uterus was cured in five weeks, and from the fact that this treatment followed without detriment an attack of peri-uterine

* "Just after the war" Dr. Taliaferro made a practice of packing the uterus with strips of cloth with a view to medication, but found that in a few hours they were invariably forced out. In the summer of 1882 I successfully dilated the uterus with cotton tampon for the removal of a fibroid polypus, three inches in diameter, without having the packing thrown out.

inflammation, while there yet remained inflammatory deposits in the pelvis.

Case III.—This case is an inmate of our infirmary and still under treatment. She is a large and corpulent woman, very anæmic, has been unwell since her last childbirth, thirteen years ago, and bleeding from the uterus for five years almost constantly. Slight exertion caused a great increase in the flow; she was, therefore, confined to the bed a great part of the time. She gave no history of peri-uterine inflammation. The uterus was sub-involuted, and fully as large as a three-month pregnancy. There were large fungous granulations throughout the cavity extending to the external os. Deep lacerations of the cervix extended on both sides to the vaginal junction. There was great distress and soreness in the rectum, due to the presence of a hard ball of fecal matter. This mass was about the size of an orange, somewhat oblong and pointed at the lower extremity. For thirteen months it had been presenting at the anus during defecation, receding to the sigmoid flexure when the bowel was inactive. The act of defecation caused great pain and distressing tenesmus.

A surgeon of acknowledged reputation visited her at her home in a distant portion of this State, and as she states made a diagnosis of fibroid tumor of the uterus and stretched the sphincter ani. The day of her entrance to our infirmary, I pressed the mass down in the pelvis with one hand from above the brim, and by the aid of my finger and ox-gall enematas completely cleared the rectum. This put an immediate end to the painful defecation. The following day we began the intra-uterine packing with little rolls of cotton about half the size of a lead pencil and about fifteen inches long. One of these was passed through the patulous canal into the cavity of the uterus to the fundus, and this followed by others until the whole organ was filled up, and then a firm tampon was placed in the vaginal vault. This latter caused some pain from pressure upon the sore rectum, but the soreness rapidly grew better.

Day after day this treatment was carried out, gradually increasing the length and number of the little cotton twists that were placed in the womb. As the first few dressings were removed the blood welled up from the uterus like a little spring. It was, indeed, alarming to persons not accustomed to such sights and treatments, but as it was promptly checked by the fresh packing, which was ready to be introduced as soon as the old one was withdrawn, no blood of any consequence was lost. This was repeated at each treatment, but in a less degree, until the end of the third week, when there was only a stain of blood on the dressing.

At this time the length of the packing-twist

was one and three-fourths yard. All this was carried beyond the internal os, and about the same quantity or more was packed in the cervix.

At the present writing there is some stain of blood as the dressings are withdrawn, but nothing like a bleeding ever occurs. There is quite a profuse coating of pus upon the cotton when taken away. The cessation of the hemorrhage and the appearance of pus show a destruction of the granulation, but the packing is continued for further reduction of the sub-involution.

The uterus at first seemed to dilate, but now, the fifth week, it is regaining its proper tone and vigor; it seems to contract, and is reducing both in volume and calibre of its cavity, and we now have to introduce smaller packings.

These cases are reported rather briefly, and many details of the general treatment left out, as it was the effect of the packing that we wish to note. The first case was treated at the office, the second at her residence, and the third is an inmate of our infirmary.—V. H. TALIAFERRO, M.D., Professor of Obstetrics and Diseases of Women and Children in the Atlanta Medical College, Atlanta, Georgia, *Atlanta Medical and Surgical Journal*.

SOME DISORDERS OF ADOLESCENCE, ESPECIALLY IN GIRLS.—There is a large amount of literature on this subject, but it is mostly confined to monographs or articles appearing in popular magazines. These do undoubtedly a great deal of good, but at the same time it seems to me that there is a medical side of the question which is equally important.

We all recognize the very great importance of impressing upon mothers the value of all that tends toward muscular development in growing girls. They should be symmetrically developed, should have full chests, straight backs, and strong limbs. We should also urge the importance of clothing of light weight and loose fitting, the principal strain being on the shoulders, not on the waist and hips, and also the evil results of cramped, stooped positions in the school-room, eye strain, and bad ventilation. We all urge these matters daily, and we all know but little attention is paid to them. But there are certain forms of various disorders which occur about the time of the second dentition which deserve more than a passing notice. These are manifested either as chorea, nervous excitement such as night terrors and various mental disturbances misnamed hysteria, gastro-intestinal disorders, and evidences of mal-nutrition. The child will probably become languid, suffer with frontal headache, become peculiar in her disposition and show fits of temper, shun society of other children, lose her appetite, become despondent, and possibly develop a local twitching of some of the facial muscles. It is customary to say

that this is all reflex,* is possibly the warning that the system is undergoing some change preparatory to the menstrual functions—that it is in fact a true hysteria. This may or may not be the case. My own impression is that it is often due to the anæmia brought about by rapid growth and development, with faulty assimilation and deficient oxygenation. In my experience such cases present two types, the one essentially nervous, just described, the other the so-called strumous or lymphatic, in whom the want of proper assimilation is shown by a large amount of stored fat, and the anæmia by excessive pallor.

In the first case, the mother will tell you at once that her child cannot take iron, that she has frequent nose bleeds, and that she feels confident that if iron could be given it would be of great service. The nervous system seems to run riot, but this very excitement in itself is an evidence of the demand on the part of nature for a blood supply which is nutritious and well oxygenated. All the exercise in the world, all the most nutritious and sustaining of foods, will have no effect, until the digestive organs are made to perform their normal functions. If you examine the tongue you will find it coated, the breath is heavy, the bowels are sluggish, the appetite is perverted, the child craves extraordinary articles of food, especially acids and sweets. She has a disgust for her regular meals. There is flatulence, cardiac palpitations, asthma after exertion. The urine is either scanty and high colored, or very copious and of low specific gravity. If the menses have been established they are scanty, colorless, and irregular, or there is a leucorrhœa. In these cases the recommendation of popular writers for gymnastics, friction, mild diet, etc., are admirable after the digestive organs have been cleared of their accumulation of ashes, and the normal functions whipped into activity. For an infant I have the greatest confidence in small doses of calomel, with soda bicarb. and ipecac., frequently repeated; but for the cases we now speak of, I much prefer the following:—

R. Acid nitro-muriat. dil. . . . ℥xl.
Succus tarax. ℥lxxx.
Vin. pepsin q. s. ad. ʒj.

Sig.—Teaspoonful in water after meals three times daily, with a half teaspoonful of the fluid extract cascara sagrada every night until the bowels become regular.

After taking these for a few days, if the tongue has become clean, the complexion clearer, the patient can be placed on the following instead:—

R. Hydrarg. chl. corros. . . . gr. ⅓.
Liq. arsenici chlor. ℥xij.
Tinct. ferri chlor. ʒj.
Syr. limonis ʒj.
Aquæ q. s. ad. fʒvj.

Sig.—Tablespoonful after meals, and the laxative continued, if necessary, at night.

As far as the general treatment is concerned, the little patient should be sponged every morning with tepid water, she should stand in a tub, and have a pitcher of it poured down her spine from the nape of her neck, and then be thoroughly rubbed with a soft Turkish towel into a glow. The breakfast should consist of warm milk, or cocoa, a soft-boiled egg, or rare pieces of steak or chop, either oatmeal, cracked wheat, grits, or Indian meal alternating; bread and butter, with hot cakes. For dinner, soup, rare meat, fresh vegetables, very little water. For supper, stewed fruits, bread and butter, warm milk or cocoa, with tea, not coffee. She should retire early, and not be permitted to read at night. The supply of oxygen should come from out-door exercise, not an over-indulgence in walks or games that fatigue; let the school hours be limited to the early part of the day, and avoid that abomination of preparing lessons in the afternoon or evening for next day's recitations.

In about a week's time the girl will be able to bear the iron alone, and the tincture of the chloride can be given in ten- or fifteen-drop doses for some time, or a chalybeate water can be given with arsenic. The digestive organs will now also tolerate milk in large quantities, provided it is of medium richness, is fresh, and given warm.

But this is not all. There are very many cases of a highly nervous type, which despite the most careful treatment, will not improve at home. The constant association with parents of like temperament, however solicitous they may be in carrying out instructions, is of itself a cause of nervous irritation.

It may be necessary to send such children from home, either to some relative, living possibly in the country or some distant city, or perhaps to some suburban or country boarding-school, where a thorough change of air and scene, the association with girls of a different temperament, will work wonders.

For the strumous type, the same preparatory treatment may be instituted, and for such I would not hesitate to push the iron, phosphates, and cod-liver oil as soon as possible. Change of air to the sea-shore is advisable. There is little trouble in the home treatment of these latter cases; there is rarely a conflict of authority in such families.

Although I have intimated that the ovaries have little to do with the production of these conditions, I feel satisfied that the weakness, consti-

* Sufficient attention has not been called to the disturbances caused by the pressure of the twelfth year molars. These may show themselves in either dental neuralgia, or, in fact, any form of trifacial neuralgia, gastric disorders, or mental peculiarities, amounting to melancholia or symptoms of acute meningial irritation.

pation, faulty clothing, eye strain, or dental pressure, will eventually tend to the production of uterine derangements—anæmia being the cause, due to deficient assimilation, from digestive disturbances, want of fresh air and healthful exercise, reflex irritation, and afterwards uterine disorders follow *post hoc* instead of *propter hoc*.—JOHN M. KEATING, M.D., *Medical and Surgical Reporter*.

BOOK REVIEWS.

How we Treat Wounds to-day. By ROBERT T. MORRIS, M.D. Second edition. New York and London: G. P. Putnam's Sons, 1886.

This book is rich in bombast, but destitute of any practical value.

The Healing of Arteries after Ligature in Man and Animals. By J. COLLINS WARREN, M.D., Assistant Professor of Surgery, Harvard University, etc. New York: William Wood & Co., 1886.

This scholarly monograph contains an elaborate description of the different processes which take place in the walls of arteries from the moment of ligature until the formation of the final cicatrix occurs, and is worthy of the careful consideration of every practical surgeon.

A Manual of Diseases of the Skin. By BALMANO SQUIRE, M.B., London, Surgeon to the British Hospital for Diseases of the Skin, London, England. Chicago: A. N. Marquis & Co., 1886.

This valuable little book contains in an epitomized form the results of the author's extended experience in the treatment of diseases of the skin, and will be found to be a valuable addition to the working library of every practical physician.

A Manual of Practical Therapeutics Considered with Reference to Articles of the Materia Medica. By EDWARD JOHN WARING, C. I. E., M.D., and DUDLEY W. BUXTON, M.D., B.S. Fourth edition. Philadelphia: P. Blackiston, Son & Co., 1886.

Waring's Manual of Therapeutics has been so favorably known for the last generation, that no extended commendatory notice is necessary for it now. Suffice it to say that the present edition has been thoroughly revised by Dr. Dudley W. Buxton, the accomplished assistant of Dr. Wm. Murrell, Professor of Medicine in University College, London, and that the additions which were made to it by him have materially increased its practical value and rendered it indispensable to every practitioner of medicine.

Diseases of the Stomach and Intestines. A Manual of Clinical Therapeutics for the Student and Practitioner. By Professor DUJARDIN-BEAUMETZ. Translated from the fourth French edition. By E. P. HURD, M.D., Newburyport, Mass. With illustrations and chromo-lithograph. New York: Wm. Wood & Co., 1886.

This valuable treatise which has been issued as the August number of Wood's Medical Library, is one of the most noteworthy publications of the year. Its author is so widely known as a clinician and therapist, that there will be a general desire to become acquainted with the methods of treatment which have been so successful in his hands.

A Laboratory Guide in Urinalysis and Toxicology. By R. A. WITTHAUS, A.M., M.D., Professor of Chemistry and Physics in the Medical Department of the University of the City of New York, Professor of Chemistry and Toxicology in the Medical Department University of Vermont and in the University of Buffalo, etc. New York: William Wood & Co., 1886.

This admirable little book contains a complete list of the most approved tests for the morbid products found in urine as well as for the various vegetable, mineral, and volatile substances which are capable of producing poisonous effects when introduced accidentally or intentionally into the circulation.

The Physician Himself and what he should add to his Scientific Requirements in order to secure Success. By D. W. CATTELL, M.D., late Professor of Pathology in the College of Physicians and Surgeons of Baltimore. Fifth edition, thoroughly revised. Baltimore: Cushings & Bailey.

The appearance of a fifth edition of this valuable work, sufficiently attests the appreciation in which it is deservedly held by the medical profession. It is a book replete with valuable suggestions and thoughtful admonition, and one which no physician can afford to do without.

Cancer of the Mouth, Tongue, and Alimentary Tract: Their Pathology, Symptoms, Diagnosis, and Treatment. By FREDERIC BOWSEMAN JESSETT, F.R.C.S., England, Surgeon to the Cancer Hospital, Brompton. With numerous illustrations. London: J. & A. Churchill, 1886.

This valuable monograph is one of the most important contributions that has yet been made to the literature of carcinomatous affections. It embodies the results of the author's wide researches as well as extended experience, and clearly indicates the line upon which future inquiries into the origin and progress of this baffling class of diseases must be made in order to obtain a measurable degree of success in their treatment.

COMMERCIAL NEWS.

MEDICINE *vs.* FAITH.

Medicine is more successful than faith, as a curative agent, because it has the inside track.—*Ex.*

TREATMENT OF GONORRHOEA.

Dr. C. L. Mitchell, 1016 Cherry Street, Philadelphia, has issued a very valuable twenty-four page pamphlet on "Treatment of Gonorrhœa and its Sequelæ," which he will send *gratis* to any physician who mentions THE MEDICAL BULLETIN. Although the treatment indicated is with special reference to the efficiency of the Soluble Medicated Bougies manufactured by Dr. Mitchell, yet the pamphlet contains many hints that must be of much value to every physician. It costs nothing, and gives much information. Send for it.

JEQUIRITY?

Oh, yes, that was a bean introduced some two years ago, as a remedy for trachoma. Has anyone heard of it lately, or has it lapsed into innocuous desuetude.—*Medical Age.*

SOLUBLE HYPODERMIC TABLETS.

The solubility of Sharp & Dohme's "Hypodermic Tablets" is almost marvelous. We placed one of them in cold water and saw it entirely dissolve in just two seconds. Every physician who has experienced inconvenience and disappointment from the use of solutions in hypodermatic medication, will do well to send to S. & D. for a sample of their Soluble Tablets, saying that he is acting on the advice of THE MEDICAL BULLETIN. See their advertisement on page 4.

RELIGION *vs.* SCIENCE.

"My pa," said one small boy, "is a preacher, and is sure to go to heaven." "Huh!" said the other small boy, "that ain't nothin'. My pa is a doctor and can kill your old pa."—*Ex.*

SUBSTITUTION.

Does the profession realize how much injury is done to physicians and their patients by the *substitution* of spurious, or the so-called "just as good" preparations; *in place* of goods of standard reputation?

The following letter from Dr. Springer is a case in point:—

VAN BUREN, OHIO, Sept. 10, 1886.

Messrs. Battle & Co., St. Louis, Mo.

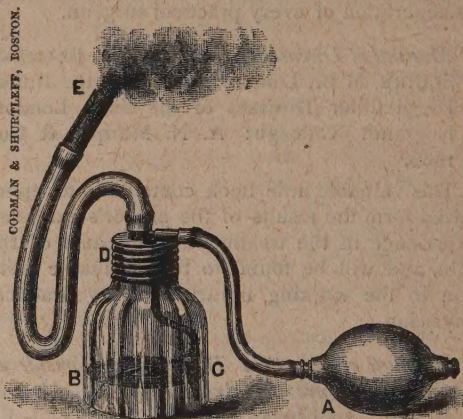
GENTLEMEN:—In the case of "Insomnia," which I reported to you in May last, and wherein it required seven drachm doses (hourly, 1 drachm) to produce sleep by Bromidia bought at pharmacy

in Findlay—it required but one drachm, repeated in *one* hour, to produce a good night's rest, of the sample bottle you sent me. I also use the Bromidia (Battle & Co.) with the best results in "cholera infantum," and in "hysteria."

Am satisfied that the article bought at Findlay was "spurious." GEORGE SPRINGER, M.D.

NEW ATOMIZER.

Some time since THE MEDICAL BULLETIN had advice from Codman & Shurtleff that a prominent specialist on diseases of the throat had expressed his delight with their atomizers, and had ordered one of each kind. This led us to inquire into the merits of these apparatuses and we find they are based upon the invention of Dr. Henry K. Oliver, made so long ago as 1866, and described by him in the Boston Medical and Surgical Journal for March of that year. Renewed and very general interest in this invention has been manifested of late, growing out of the recognition by Dr. George A. Evans and other observers, of the fact that the atomized medicine when suitably constituted by addition of glycerine, or other suitable vehicle, after being broken into fine spray by striking against a hard surface, as described by Dr. Oliver, is not readily absorbed into the atmosphere, but will continue to float for a long time upon it.



In the cut the atomized fluid is represented as issuing from the mouth-piece in a smoky cloud, after passing through about twelve inches of tubing and continuing in the air like mist. Possessing this quality it is evidently adapted to be received into the air-cells of the lungs, into which it surely penetrates, as repeatedly proved by many careful observers.

A full description of this apparatus, and others of greater efficiency, designed for the employment of air more highly compressed and in greater volume than it is possible to attain with hand-bulbs, will be sent to any physician who will mention THE MEDICAL BULLETIN.